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THE UNIVERSITY OF ALBERTA

THE LABOUR DISPUTES OF ALBERTA NURSES:

1977-1982



BY

JUDITH M. HIBBERD

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

OF DOCTOR OF PHILOSOPHY

IN

HEALTH CARE PLANNING AND EVALUATION

DEPARTMENT OF EDUCATIONAL ADMINISTRATION

EDMONTON, ALBERTA

SPRING 1987

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "The Labour Disputes of Alberta Nurses: 1977-1982" submitted by Judith M. Hibberd in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Educational Administration (Health Care Planning and Evaluation).

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ABSTRACT

Collective bargaining by Alberta nurses began as a membership program of the professional nurses' association. The program was reconstituted as an independent trade union for nurses in 1977, and within the next six years, nurses had conducted three province-wide strikes. The purpose of this historical case study was to record the circumstances of that six-year period in the collective bargaining relationship between nurses and hospital employers, and to determine the causes of the strikes.

The research approach taken was the development of grounded theory (Glaser and Strauss, 1967), and many sources of data were used including public, institutional, and personal documents. Interviews were held with negotiators, elected and appointed officers of union and management organizations, politicians, and others. Highlights of the history of the sociopolitical context of labour relations in Alberta were presented, and the history of the collective bargaining relationship was traced back to its origin.

Several themes emerged from the analysis, and multiple causal factors were identified for each strike. Because of the similarity in causal factors among the strikes, it was concluded that the disputes could be explained as a series of similar events. It was argued that the strikes were caused by a combination of circumstances including union militancy, certain structural aspects of collective bargaining in the Canadian parapublic sector, and economic factors.

The strikes were said to be symptomatic of a protest movement among nurses which was fostered by strong leaders committed to union

ideology. Negotiations in every case were constrained by extraordinarily high economic demands on the part of the union, public wage restraint policies, last dollar government funding, the system of prospective hospital budgeting, and government intervention in all of the strikes. Professional issues were central to the arguments underlying the disputes, but there was no evidence to suggest that they were more important to nurses than salaries, working conditions, job security, and work schedule rules to promote the normalization of lifestyles. Some implications of the study were discussed, including the future of the relationship between the parties, and the management of nursing personnel resources.

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J.M.H.

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CHAPTER I

Introduction

Purpose and Research Objectives

The purpose of this study was to investigate a series of legal strikes by registered nurses to determine the underlying cause or causes. It was expected that the findings of the study would contribute to an understanding of the collective bargaining relationship between nurses and their employers. The strikes occurred in various hospitals throughout the Province of Alberta between the years 1977 and 1982, creating major disruptions in the operation and availability of health services to the public. The strikes were not the first by registered nurses in Canada, nor even the first in Alberta. They were, however, some of the broadest in scope in the hospital industry, that is, the number of nurses involved, and the fact that there were three strikes within a six-year period constituted a record unsurpassed elsewhere in Canada either then or now, four years later.

Collective bargaining by nurses and their employers had been in effect for twelve years prior to the first of the three strikes. Within the framework of the provincial labour legislation, the parties had conducted periodic negotiations on a province-wide basis. During those years, nurses were represented by their professional association, the Alberta Association of Registered Nurses (AARN). However, a few weeks before the first strike in 1977, the collective bargaining division of the AARN separated from the parent organization and established an independent trade union, the United Nurses of

Alberta (UNA). In Table 1, the details of the structure of bargaining, and the duration and scope of the three strikes are presented.

Table 1

Strikes by Alberta Nurses, 1977-1982

	1977	1980	1982
Hospital boards and local bargaining units	68	86	92
Total number of nurses represented by the union	6000	6600	8955
Number of hospitals with nurses on strike	7	81	60
Length of strike in days	6	10	23
Number of nurses on strike	2500	6400	6000

The number of hospital boards and corresponding locals of the nurses' union was 68 in 1977, rising to 86 in 1980, and 92 in 1982. In the first strike, 2500 nurses withdrew their services in seven of the largest hospitals for a total of six days. The second strike was the largest of the three in scope involving 81 hospital boards and 6400 nurses, and it continued for ten days, the last seven of which were in defiance of a government Order-in-Council to return to work. The third strike occurred in 1982 and was generally less well supported by the nurses. Sixty hospitals were struck for 23 days by approximately 6000 nurses.

Third party intermediaries were employed in each of the disputes and none was successful in bringing about an agreement. A summary of the conflict resolution procedures is provided in Table 2. The labour statute under which the majority of hospitals negotiated contained provisions for the declaration of an emergency in the event that circumstances were deemed to place the health and/or safety of the public at risk, and these provisions were invoked by the government in both the first and second strikes. In the third strike, the government enacted special back-to-work legislation which included extraordinary penalties for non-compliance including decertification of the union. The first dispute was settled by arbitration, the second by negotiation, and the third by arbitration following 16 days of public hearings. Detailed accounts of the three strikes can be found in Appendices A, B, and C, respectively.

Table 2

Conflict Resolution Procedures

1977	1980	1982
Conciliation	Conciliation Conciliation Board Mediation	Mediation Disputes Inquiry Board
Strike	Strike	Strike
Order-in-Council	Order-in-Council	Back-to-work legislation
Declaration of Public Emergency	Declaration of Public Emergency	Public Emergency Tribunal appointed
Arbitrated award	Negotiated settlement	Arbitrated award

The events described above seemed to represent a turning point in the affairs of nursing in Alberta and were therefore, considered to be a subject worthy of investigation. Several interesting lines of inquiry might have been selected. For example, was the divestment of the collective bargaining function by the AARN an indication of maturation and of increasing professionalization in nursing? Or was the establishment of a trade union of nurses evidence of a deprofessionalizing trend in nursing? The separation of the professional and socioeconomic divisions of the AARN seemed to be of sufficient historical significance to warrant the systematic documentation of that period in the development of nursing organizations in Alberta. Therefore, one of the research objectives was to provide an historical record of the development of collective bargaining by nurses in Alberta up to, and including, the strikes of 1977, 1980, and 1982.

A second research objective was to address the question of why these strikes took place. It is reported that 90 percent of all negotiations in Canada lead to collective agreement without the use of strikes or lockouts (Craig, 1983), yet nurses and their hospital employers could not reach agreement in three out of four rounds of bargaining in the six-year period under investigation. This question and several other subsidiary questions were the subject of discussions held with people who played leading roles in the disputes--from the union, management, the government, and with other strategic informants identified by the parties. The subsidiary questions of interest to the investigator included: What were the causes of these strikes? Were there important predisposing factors in these dis-

putés? How did the participants themselves explain the strikes? What was the nature of the issues in dispute?

The third research objective was to develop the elements of a theory to explain the strikes. It is Gouldner (1954) who observes that a strike is an enormously complex social phenomenon "which in its totality, is never susceptible to complete description, let alone complete explanation" (p. 65), and the truth of this statement became abundantly clear as the literature was reviewed, and indeed, during the course of this research. In consideration of how these research objectives might be achieved, a case study using grounded theory seemed to be the most appropriate research approach, in which data would be collected from interviews with strategic informants, and from a broad range of public, private, and institutional documents. Details of the research approach and method are outlined in Chapter 3.

Significance of the Study

One of the more salient trends in the Canadian health care system in recent years has been the unionization of its workforce. The interest shown by health workers in collective bargaining was an integral part of a larger social movement in the public sector that began in the 1960s, and which led to an unprecedented growth in unions among government employees. Historically, the socioeconomic status of health workers, particularly hospital employees, has lagged behind private sector and other public sector workers. Although substantial gains have been made in levels of compensation, fringe benefits and working conditions, the trend has been accompanied by a

growing incidence of labour unrest. Prior to the federal government's anti-inflation program introduced in 1975, Canada was reputed to have one of the worst records of work stoppages among the Western industrial economies (Christensen, 1980).

The health care industry is a labour intensive one, and many of the services it provides are regarded as essential. Health workers can be described as "parapublic" employees, which is to say that while they are not directly employed by governments, their services are supported almost entirely with public funds. The labour force in the health care system is characterized by occupational differentiation, specialization, professionalization, and marked status differentials; and a disproportionate number of the workers are female. Despite all these features of the workforce, the empirical literature on labour relations and collective bargaining by health workers is surprisingly limited. Inasmuch as there has been considerable debate in the labour relations literature on whether or not public and parapublic employees should enjoy the same collective bargaining rights as their private sector counterparts, including the right to strike, unionization in the health field represents an interesting area for investigation.

The unionization of nurses has been an integral element of the trends identified above. The Registered Nurses' Association of British Columbia began to bargain collectively on behalf of its members in the mid-1940s, but the majority of Canadian nurses did not become actively involved in formal negotiations with employers until two decades later (Botterill-Conroy, 1980). They did so under the

auspices of their professional associations and under the umbrella of provincial labour statutes. In 1973, however, a decision of the Supreme Court of Canada established the ineligibility of the Saskatchewan Association of Registered Nurses as a bargaining agent for nurses, and with the exception of Prince Edward Island, nurses in the remaining provinces set in motion procedures which led ultimately to the establishment of independent labour unions for nurses. Thus, nurses have tended to steer an independent course, generally avoiding membership in multi-occupational bargaining units that are typical of other hospital employees.

The extent to which nurses and other health care workers have unionized in Canada can be attributed to a number of complex social factors, but there seems to be little doubt that they have adopted collective bargaining for many of the same reasons that have motivated unionized workers in general. Unionization is primarily inspired by feelings of dissatisfaction and frustration with conditions in the workplace, and beliefs that collective bargaining provides an effective means of gaining more control over the terms and conditions of employment (Kochan, 1980; Brett, 1980).

The power of collective bargaining as an instrument for advancing socioeconomic status and for making gains in the area of professional practice has been recognized by nurses. For example, there is a growing appreciation of the possibilities of counteracting the effect on salaries of government restraint in health care spending (Campbell, 1983). Moreover, through collective bargaining, inroads can be made into the traditional administrative and medical decision-

making processes in institutional settings (Acord, 1982). The drive for professionalism in nursing, as exemplified by the goal to establish a baccalaureate degree as the qualification for entry to practice (Canadian Nurses Association, 1982), may well strengthen this collective resolve. Commenting on the situation in the United States, Ginzberg (1981) predicts that due to serious shortages of nurses in that country, and the failure of administrators to recognize changes occurring in the relationship of women to the labour market, nurses are going to get tougher, and they are going to make lots of trouble in the 1980s. If these predictions are accurate, labour conflicts between nurses and their employers would seem to be a continuing future possibility.

Economic uncertainty and continuing government spending restraint require that hospital boards increase their efforts to contain expenditures even though the general situation in the health care field is one of rapidly rising costs. This has resulted in increasing pressures for operational surveillance, quality assurance, and tighter fiscal controls. Departments of nursing service generally consume at least fifty percent of hospital manpower budgets, and in some cases, as much as two thirds (Leatt, 1981). Because of the size of the nursing services budget as a single item in a global budget, it represents an attractive target for cost-cutting measures. This has been made possible because the precise contribution of nursing to the care of hospitalized patients has hitherto been difficult to demonstrate, much less to quantify objectively.

In economic terms, the value of nursing services has been hidden or, as Fagin (1983) observes, lumped into the multipurpose, routine operating costs of hospitals. The per diem rate for hospitalization, sometimes used as a basis for reimbursement, ignores the wide range and complexity of nursing care requirements generated by the needs of individual patients. Recently in the United States, much more interest in the development of techniques to quantify and rationalize institutional nursing services has occurred following changes in the reimbursement methods of hospitals. In Canada, hospitals have been funded on a global budget basis for many years, and justification of nursing staff establishments has generally relied on historical rules of thumb, and more recently, on patient classification systems and workload indices. The science of patient classification is still young, and issues of validity and reliability are being addressed. Refinements in these systems will very likely strengthen the nursing personnel budgetary process, because such systems have the potential of providing a more accurate information base upon which hospitals and their unionized nursing staff can discuss the complex issues of staffing and acceptable standards of patient care.

The decision to pursue this research was prompted by a number of concerns. The most obvious was with the practical implications of a widespread walk-out of hospital-employed nurses, and the potential impact on patients within, and awaiting entry to the hospital system. The disruption in health care services created by a strike of hospital workers, particularly nurses, is usually profound. Many adaptive responses are required in order to scale down hospital

services and to safeguard the care of patients. Interorganizational mechanisms are established to coordinate such things as: the discharge of patients from hospitals; the designation of critical care and emergency services; the transfer of critically ill patients to hospitals remaining in operation; the deployment of non-striking personnel; the flow of information; and the management of public relations, to name but a few. Under such circumstances, many unanticipated costs are generated, some of which cannot be easily calculated, for example, the cost to individuals and to the system of delayed diagnosis and treatment. There may be public and professional concerns about the quality and safety of services provided in temporarily overloaded facilities such as emergency departments and intensive care units of hospitals where nurses are not on strike. There is implicit danger in limited access to hospital services, and the postponement of urgent medical intervention creates public anxiety, especially where such things as cancer and heart disease are concerned.

Massive disruptions in health care services as outcomes of labour disputes lead inevitably to the question of whether it is right to take risks with the health, and possibly the lives, of people in a society which endorses the principle of universal accessibility to comprehensive health care services. Canadian society is committed to certain democratic ideals and human freedoms, one of which is the freedom of individuals to associate and to negotiate the terms and conditions under which their services will be employed. Inherent in the principle of free collective bargaining is the

ability to impose economic sanctions if and when the parties fail to reach an agreement. Strikes and lockouts are the usual weapons for forcing an opponent to agree to proposed terms, and although many alternatives to these particular economic sanctions have been suggested, there are few, if any, effective substitutes. The question is, when do the legal rights of one group of individuals take precedence over the legal rights of another? According to Weiler (1980), there are no issues in Canadian labour relations that generate more popular concern than those of public sector employees, the essential nature of their services, and their right to bargain collectively and to strike.

The Alberta government has an unequivocal position on these issues. Labour relations in the public sector are governed by legislation that is separate and distinct from the labour law governing employees in the private sector. The Public Service Employee Relations Act of 1977 prohibits strikes and lockouts of government employees, and in 1983 the government amended its labour statutes extending this prohibition to encompass all hospital workers and their employers. While the labour movement in Alberta has been vociferous in its opposition to these developments, launching legal appeals, and taking its complaints to the International Labour Organization (Moysa, 1984), it remains a weak political force in the province. Alberta has thus become the fourth province in Canada to deny hospital employees the right to strike, along with Ontario, Newfoundland and Prince Edward Island. Experience in Ontario and other jurisdictions, however, suggests that legal prohibition of

economic sanctions does not necessarily guarantee strike-free negotiations.

Strikes by nurses have occurred in all but one of the Canadian provinces, and it is a concern that little is known about the circumstances and conditions under which these professionals, the vast majority of whom are women, are prepared to withdraw their services. The history of the union movement reveals that women have been just as willing to refuse to work when sufficiently provoked as their male counterparts. As the participation rate of women in the labour force has increased, so too has their rate of unionization, but they still represent a small minority of the total trade union membership. The interests of women have been under-represented by unions in the past, but women are now joining unions at a higher rate than men, and are taking a greater proportion of executive positions and are benefiting from unionization (White, 1980). The research on women in unions is scarce, and accounts of strikes by female workers have often focussed on women in the blue collar occupations. The collective bargaining activities of teachers have received much attention in the labour relations literature, but studies of strikes by other professionals involving high proportions of women, including the nursing profession, have rarely been undertaken.

There are at least three reasons why this study will be of interest to the nursing profession. First, nurses are now represented in collective bargaining throughout Canada (except in Prince Edward Island) by nurses' unions that are completely independent of professional nurses' associations. The mandate of professional nurses'

associations includes the promotion of high standards of practice in the interests of the general public. The association does so through licensing of nurses and by establishing standards for nursing practice and education. From the very early days of collective bargaining in nursing, professional nurses' associations have argued that if economic rewards and working conditions are not comparable to those in similar occupations, recruitment into the profession will be jeopardized and ultimately the standards of nursing practice will be affected. The maintenance of a socioeconomic status for nurses which is acceptable to the membership remains a matter of considerable interest to professional nurses' associations, despite their diminishing role in labour relations. Nurses' unions and professional nurses' associations share the same membership to a significant extent, and the two types of organizations can be expected to monitor each other's activities in a very general way.

Second, it has been assumed in the labour relations literature that in the case of professional employees, the scope of bargaining will expand to include issues of special interest and concern to the professional discipline (Kleingartner, 1972; Ponak, 1981). Where nursing practice issues are negotiated into a collective agreement, there is potential for such issues to become the subjects of grievance arbitration, and thus to be adjudicated by someone external to the profession. This problem has thus far been avoided. In some provinces, notably Ontario, nurses' unions have negotiated a system of external adjudication into collective agreements which provides for an expert panel of nurses to deal with unresolved patient care

matters (Adams, 1980). However, this is not the case in the majority of provinces, including Alberta, and nurses' professional associations can be expected to resist union incursions into areas that fall within their legitimate mandate.

Third, for sixteen years the Canadian Nurses Association (CNA) held the position that no nurse must withdraw her services from patients no matter what the circumstances. This official ban was lifted in 1972 because the CNA recognized that without the power to strike, nurses were bargaining from a position of extreme weakness. Moreover, at that time, the socioeconomic status of nurses was declining (Mussallem, 1977). This reversal of policy by the CNA should not be interpreted as a professional blessing on the abandonment of patients during interest disputes. The question of whether or not to strike represents a serious moral and ethical dilemma for many nurses. It is of interest to note here that a code of ethics accepted by the Board of Directors of the Canadian Nurses Association was rejected by voting delegates to the 1980 Biennial Meeting primarily because withdrawal of nursing services had been identified as unethical behaviour (Canadian Nurses Association, 1980, p. 4). A new code was drawn up clearly modifying the earlier position, stating that patients are entitled to emergency services during any job action by nurses, and that nurses have a "duty of coordination and communication to take steps reasonably designed to ensure the safety of clients" (Canadian Nurses Association, 1985, p. 13). Generally speaking, nurses have been willing to provide essential services to patients in critical care areas in the event of strike. Whether

there is a role for the professional association where nurses have refused to provide emergency services is a moot point.

Registered nurses comprise the single largest occupational group in the health care system. In 1982, there were 214,776 registered nurses in Canada, 164,086 of whom were employed in nursing (Canadian Nurses Association, 1984). Nearly three quarters of these nurses were being represented in collective bargaining at that time (Glenna Rowsell, personal communication, November 16, 1982). Approximately 98 percent of Canadian nurses are female, and close to 80 percent are employed in hospitals and nursing homes (Canadian Nurses Association, 1982). In Alberta, there were 17,953 registered nurses in 1982, 15,108 of whom were employed in nursing (Canadian Nurses Association, 1984), and 10,713 of them were represented by the United Nurses of Alberta (Statistics Canada, 1984). In addition to the UNA, there were several small, independent nurses' unions in the province, as well as the University of Alberta Hospitals Staff Nurse Association with a membership of approximately 2000 (Louise Rogers, personal communication, July 18, 1986). Thus, the proportion of unionized nurses would seem to have been slightly higher in Alberta than for Canada generally at the time of the third strike under investigation.

The salary of a registered nurse has been considered a benchmark figure for the purpose of budgeting and personnel administration in hospitals. No doubt this is due, in part, to the size of the nursing staff complement and the corresponding proportion of total hospital operating expenditures generally attributed to the nursing department. Historically, the terms and conditions of employment esta-

blished for nurses have set the pattern for other hospital employees in Alberta, and this has cast the nurses' union in the role of pace setter. For this reason, the outcome of collective bargaining by nurses plays a significant part in determining the level of public spending on health worker salaries and benefits in the province. In the 1982 arbitrated settlement which followed the 23-day strike, the increases in salaries and benefits alone for nurses over the life of the collective agreement were estimated to cost the province approximately 30 million dollars (News in review, 1982).

In summary, the economic, ethical, and professional issues discussed above seemed to indicate that there were sufficient reasons for undertaking a systematic examination of the interest disputes of nurses and their hospital employers in Alberta.

Organization of the Dissertation

The following chapter contains a discussion of the nature of strikes and a selective review of literature pertaining to relevant theory and research. In Chapter 3, the research approach, method, and study limitations are presented. Chapters 4 to 7 inclusive are devoted to background information leading up to the first strike of 1977, including the sociopolitical context of labour relations in Alberta, and the history of the development of collective bargaining by representatives of hospital employers and nurses, namely, the Alberta Hospital Association (AHA), and the Alberta Association of Registered Nurses (AARN). The content of these chapters is considered to be essential for a full understanding of the events that unfolded from 1977 onwards. Specifically, Chapter 4 contains an

overview of major environmental factors in the Alberta industrial relations system, and includes sections on the distribution of hospitals in the province, and the funding of the health care system. The origin and development of the AHA is the subject of Chapter 5, and of the AARN, Chapter 6. Also in Chapter 6, the elements of the internal conflict are described that led to the secession of the collective bargaining division of the AARN, and the establishment of the United Nurses of Alberta. In Chapter 7, the collective bargaining relationship is described together with the outcomes of successive rounds of contract renewal negotiations. In Chapter 8, the results of the theoretical sampling are presented within a framework of the five major themes that emerged from the process. Causal factors for each of the strikes are identified in Chapter 9, and finally, discussion and conclusions follow in Chapter 10. The appendices include chronologies of the strikes and a list of the strategic informants.

CHAPTER II

A Selective Literature Review

This chapter contains a review of selected literature on strikes. Like so many contemporary social phenomena, strikes have attracted a good deal of theoretical debate, empirical research, and journalistic commentary. Finn (1982) observes that: "Of all human activities, the strike is probably the most misunderstood. It has generated more myths, as well as more public hostility than any other economic process" (p. 1). This literature review begins with an inquiry into the nature and elements of the strike as a form of social conflict. Next, major theoretical and research approaches to the study of strikes are examined, followed by an overview of the literature on strikes in the health field. Finally, studies of militancy and strikes in the nursing profession are discussed.

The Nature of Strikes

A newcomer to the field of labour relations is impressed by the allegorical descriptions of strikes as warfare. Contract renewal strikes, for example, are frequently planned and executed like military operations. The parties arm themselves with the weapons of the economic battlefield; warning shots are fired as the notice of strike (or lockout) is served. A struggle ensues in a test of strength as the antagonists inflict injuries (costs) on each other, while the language of picket signs is rich in pugilistic imagery (to say nothing of the behaviour of the picketers). Each party claims it has rights; management claims the right to operate the enterprise; the employees claim the right to determine the terms and conditions

under which they are prepared to work. If neither party is prepared to modify its claims to these rights, then as Bakke (1967) says, the outcome is analogous to warfare.

No two strikes would seem to occur in exactly the same circumstances, thus every strike is unique (Lane & Roberts, 1971). But at the heart of every strike there is a refusal to cooperate. Gouldner (1954) calls it a refusal to obey, or a "breakdown in the flow of consent" (p. 66). This, he says, is of specific interest to sociologists because it represents the disruption in the authority relations of a social system. In other words, a strike is the result of an inability on the part of persons in authority to obtain compliance with their decisions and directives. As such, the strike is an expression of antagonism between authority and those who must submit to it (Gubbels, 1968).

Elements of the Strike

A strike is defined by Karsh (1958) as a situation in which a number of employees collectively withdraw their labour in order to secure some immediate advantage. Hyman (1972) would add that it is a temporary cessation of work because strikers expect to return to their jobs once their complaints have been satisfied.

Except in perhaps the mildest forms of refusal to cooperate in the work place, certain elements are true of all strikes. First, a strike is a group activity—and it is from its collective nature that it derives its coercive force (Gubbels, 1968). An individual protesting alone has little persuasive power and is, moreover, inviting discipline or dismissal. Second, a strike involves a group of

individuals acting in concert to achieve some purpose. This implies communication, organization, and mobilization among the members of the group, which is best accomplished if there are leaders. Leaders coordinate individual activities and articulate the goals or grievances of the group (Karsh, 1958). Third, there is a cessation or disruption of work which creates disorder in an otherwise stable environment, threatening the established institutional rules (Dubin, 1954). Thus, there are technological consequences when workers refuse to obey (Gouldner, 1954). Few strikes occur without some inconvenience to third parties. In the hospital industry more than inconvenience is at stake because withdrawal of services may threaten the health, safety, and even lives of the public. As strikes in the public sector do not usually cause the same degree of economic hardship for the employer as in the private sector, union leaders in the public sector tend to count on the adverse effects on third parties to force concessions from employers.

Finally, the strike is ultimately resolved and under normal circumstances, resolution is accomplished by a cooperative act of agreement. The agreement brings about a change in the rules and a new basis for the employment relationship. As Karsh (1958) points out, there is usually no clear cut standard as to what constitutes a "fair day's pay for a fair day's work" and so the agreement becomes the sole criterion of fairness and equity:

Thus, the strike, or threat of strike, is the ultimate device whereby the competing interests of antagonistic parties are expediently resolved leading to a modus operandi which permits both sides to accommodate their differences and live with one another. (p. 13)

The prototypical strike requires no mediation by a third party, nor the imposition of an arbitrated settlement; as such, it can be a constructive force for social change. Both parties have a stake in the contract because they jointly own it. In this way, collective bargaining represents a device for bringing social conflict to a successful resolution. The institutionalization of conflict in this manner serves as a stabilizing influence within the industrial relations system, and within society as a whole (Dubin, 1954).

Types of Strike

The strike may take a number of tactical forms. Before the days of protective labour laws, there were fewer ways of expressing discontent or influencing the decisions of an employer without fear of retribution. Nurses typically staged demonstrations or resigned en masse in pressing their socioeconomic interests (Cormick, 1969; Miller & Dodson, 1977). Other forms of protest included slow-downs, sit-ins, sick-outs, work-to-rule, and acts of employment sabotage.

A typology of strikes originating in the literature of Britain distinguishes between official and unofficial strikes (Knowles, 1952). Whether or not a strike is official depends upon whether the strike has received the approval of the executive committee of the union. The unofficial strike is generally one which arises more or less spontaneously on the shop floor; this type of strike is the norm in the United Kingdom (Hyman, 1972; Batstone, Boraston, & Frenkel, 1978). Strikes can also be categorized according to the status of the contract: for example, first agreement strikes; contract renewal strikes; and strikes that occur during the term of an agreement

(Fisher, 1981). Strikes during the term of an agreement are illegal in all of the Canadian provinces with the exception of Saskatchewan. Notwithstanding, these strikes account for 23.2 percent of all strikes and lockouts in Canada (Anderson & Gunderson, 1982).

It is important to distinguish between the different types of strikes so that when comparisons are made the same type of social action is in fact being compared (Eldridge, 1968). Much of the case study research concentrates on unofficial strikes which are often triggered by a single incident in the work place, taking the form of a revolt in which all the normal constitutional channels are abandoned. Demands may even be formulated after such a strike takes place (Lane & Roberts, 1971). In contrast, first agreement and contract renewal strikes are planned and organized by the union. Union members often have several days in which to decide whether or not to support a strike, and an opportunity to cast a secret ballot indicating their individual decisions.

The strikes being investigated in this study were all planned and organized by the union. More importantly, they were legally constituted and occurred during the course of the contract renewal process.

The Causes of Strikes

Macroanalyses

In recent years, Canada has sustained a high level of strike activity compared with other countries. It has been estimated that in the 1970s, Canada ranked second only to Italy in days lost per worker as a result of strikes (Anderson and Gunderson, 1982). Craig

(1983) reports that in 1977, 10 percent of all strikes in Canada lasted between 50 and 99 days and accounted for 30 percent of work time lost; a further 4 percent lasted 100-199 days accounting for 17 percent of time lost. Thus, 14 percent of the strikes accounted for 47 percent of all time lost from work, suggesting that "Canada's problem is not the number of strikes, but rather their duration" (Craig, 1983, p. 281).

The duration of strikes in the public sector in Canada is less on average than in the private sector, according to Christensen (1980). One argument is that the public sector strike is a political weapon rather than an economic one because withdrawal of the type of service provided by public employees leads to considerable inconvenience for the public, that is, the voters. Governments may be less willing to risk public displeasure caused by a strike and, therefore, less willing to resist union demands. Taxpayers may not feel the impact of the costs of settlement for months or even years, because as Christensen notes, those costs can be "hidden in the bowels of an incomprehensible public budget" (1980, p. 54). Government employers are not constrained by loss of either income or business as a result of a strike by their employees, hence the economic costs of a strike are higher for unions than for employers in the public sector.

According to Smith (1976), there are two major approaches to the analysis of strike causation. The first is described as the socio-political approach that focuses chiefly on the militancy of union leaders and their members to explain fluctuations in the level of

strike activity. The sociopolitical school of thought argues that prosperity and full employment tend to strengthen the power of unions while lowering the resistance of employers to union demands. Conversely, in times of recession, union power is weakened and employers are less likely to grant concessions. Thus, the stronger the bargaining power of unions the more likelihood there is of strikes.

Smith (1976) rejects this in favour of the second approach, namely, that of economics, suggesting that the most important single factor in explaining the level of strike activity in Canada between 1959 and 1974 is the impact of the rate of inflation. Macroanalytic studies, that is, research aimed at examining differing aggregate levels of strike activity across nations or across industries, have generally shown that there is a positive relationship between the incidence of strikes and the business cycle. Economic variables such as the state of the labour market, real wages, Gross National Product, unemployment, and inflation are said to be the primary determinants of strikes (Smith, 1972).

Ingham (1974) argues that the militancy theory provides only a partial view. He contends that to explain differences in industrial conflict between Western capitalist societies, it is necessary to examine the effects of variations in certain dimensions of the industrial infrastructures, for example, industrial concentration, the complexity of technical and organizational structures, product differentiation and specialization. Differences in levels of industrial conflict have been linked to political systems; for example, the tactical use of strikes as a political device can be expected to

have a differential impact on the level of strike activity in a given country (Kochan, 1980).

Inter-industrial studies have sought to explain the strike-proneness of certain industries through the identification of structural variables. Kerr and Siegel (1954) in their classic study, suggested that the degree of integration or lack of integration of the worker in society would in part explain the high propensity to strike observed in the mining, maritime, and longshore industries. Other theorists have drawn attention to the role of agitators, communications in the work group, and technology of the work place as major explanatory variables (Hyman, 1972). The structure of bargaining is also regarded as an important determinant of strikes; in particular, it is hypothesized that the more decentralized collective bargaining the greater the likelihood of strikes (Roomkin, 1976; Kochan, 1980).

Empirical studies at the macroanalytic level have received much methodological criticism. Researchers have generally examined one or more of three dimensions of strike activity: the frequency, or prevalence of strikes; the breadth, or number of workers involved in strikes; and the duration, or length of strikes (Stern, 1978). Stern notes that "there is a great diversity of measures of each of these dimensions, making the task of comparisons and interpretation of results difficult. Apart from this, quantitative studies using macro level data preclude consideration of the influence of collective bargaining processes and local employment conditions. Kelly (1976), in proposing three additional measures of strike activity, notes that

it is necessary to relate measures of strike activity to the level of bargaining. For example, the incidence of strike, he suggests, should be shown as a proportion of the total number of contract settlements. Even so, theories of the frequency, breadth, and duration of strikes may be only partly successful in predicting and/or explaining the occurrence of particular strikes at the collective bargaining level.

Microanalyses

Explanations of strike activity at the collective bargaining level have depended substantially on bargaining theory. Contributions to bargaining theory have come from various disciplines, to wit, economics, sociology, game theory, and behavioural sciences. Bargaining power has been one of the central concepts of such theories. Bacharach and Lawler (1981) describe the process of negotiations as follows:

Each party comes to the bargaining table with a certain power base, with the wherewithall to concede or refuse conditions desired by the opponent. Whether the conflicting parties are nations, corporations, or unions, the bargaining is a process of social interaction through which each party tries to maximize its gains and minimize its losses. (p. ix)

One of the most influential theories of bargaining power is that of Chamberlain and Kuhn (1965). Bargaining power is defined in terms of the opponent's willingness to agree to a party's terms. Such willingness in turn depends upon the cost of disagreeing with those terms relative to the cost of agreeing with them. The cost, in this case, is broadly defined to include non-monetary considerations. While there have been many modifications of this theory, the notion of imposing costs on the opponent during impasse resolution proce-

dures is widely accepted. Of course, all this assumes that decisions made at the bargaining table are rational.

Fisher (1981) states that bargaining theorists have traditionally explained interest dispute strikes in terms of strike as an investment. Simply stated, the worker invests what might be lost during a strike in order to induce the employer to improve on his final offer. By a somewhat complicated calculation, union leaders should be able to decide whether the cost outweighs the benefit of strike action. If the strike issue is one solely of wages, then one week of strike would have to yield at least a two percent increase in wages in order to recover the initial investment over one year. Hence, whether or not strikes pay has been a much debated question among both unions and employers.

Negotiations as a source of conflict. It has been said that most strikes occur as a result of faulty negotiations (Hicks, 1957). While there are no formal qualifications for bargaining as such, there is some evidence that the experience of negotiators affects the outcomes of bargaining, skilled negotiators tending to have fewer strikes (Reder & Neumann, 1980; Harris, Rausch, & Ryan, 1982). Negotiating over terms and conditions of employment, sometimes referred to as "distributive bargaining" (Walton & McKersie, 1965), is a process for resolving pure conflicts of interest. A wide range of strategies, tactics, rituals, and planned behaviours are adopted, often in lengthy, stressful, and emotionally charged sessions. The goal is to reach agreement, and the penalties for disagreement include more conflict and more cost. An impasse occurs when neither

party is willing to compromise.

A strong stand taken on a particular issue may later make concessions difficult, if not impossible, without loss of face. Hostilities and charges of failure to bargain in good faith, and a host of other interpersonal difficulties may contribute to the development of an impasse. Moreover, the probability of an impasse or strike is increased where "phantom bargaining" exists. Phantom bargaining refers to the situation in which a negotiator must defer to an external authority before giving a commitment at the bargaining table. Public sector collective bargaining may be constrained in this way particularly where public incomes policies are in effect. Inadequate decision-making authority of negotiators may provoke a strike to bring the real decision-makers into the bargaining process (Kochan, 1980).

Intraorganizational bargaining refers to the process of reaching agreement on goals and tactics within either the union or management organization (Walton & McKersie, 1965). Factions and power struggles within either the union or management bargaining teams increase the probability of strikes, as well as the duration of strikes (Lane & Roberts, 1971). On this point Ashenfelter and Johnson (1969) propose that union leaders be considered a third party to labour-management negotiations. They suggest that the goals of union leaders for political survival may be more important to them than the bargaining objectives of the rank and file membership. Calling a strike, for example, would serve to lower the expectations of the membership, obviating the need for the leaders to recommend an unfavourable

settlement. The problem of conflicting goals within a bargaining group is not unique to unions. Reaching consensus on bargaining objectives among the diverse constituents of an employers' association may be just as difficult, with similar implications for the course of negotiations.

Two other factors that may influence the development of an impasse have to do with the role of information, and the history of the collective bargaining relationship. The role of information is a prominent theme in theories of bargaining. Neither party possesses complete information on an opponent's position on the issues, nor do the parties know what the final outcome of bargaining will be. Decision-making therefore, occurs in a climate of uncertainty (Williams, 1982). Bluff and counter-bluffs occur, and as Stewart (1977) observes, the system cannot withstand candour. While the drama is played out, each party narrowly calculates just what it can put across the other, testing out the opponent's strength and position on the issues. A miscalculation can readily lead to an impasse. Finally, the history of the collective bargaining relationship may be a factor in determining the outcome of a given round of bargaining. Kochan (1980) cites a study in which it was found that one or more strikes in previous rounds of bargaining increased the probability of a strike in a current round of bargaining. Other researchers have found that bargaining units may develop a tendency to rely on particular types of impasse procedures over a period of time (Kochan & Baderschneider, 1978; Anderson, 1981).

Case study research. Much of what is known about strikes at the collective bargaining level is derived from case studies. Investiga-

tors generally seek to shed light on the meaning of the strike experience from the participants' points of view. The case study provides an opportunity to look more closely at the nature of the issues over which the parties disagree. When professionals bargain collectively, they are expected to raise issues which go to the very core of the employment relationship, posing dilemmas as to the extent to which they may exercise control over the quality and delivery of services to clients. For example, studies by Klaus (1969) and Byrne (1981) serve to illuminate the professional concerns of teachers about their role in the classroom and in the process of collective bargaining. As a method, the case study is limited in the extent to which comparisons and generalizations can be made. Classic examples of case studies of strike include those of Gouldner (1954), Karsh (1958), and Lane and Roberts (1971). Case study research tends to focus on unofficial strikes, but it provides a useful source of insights on individual and group behaviour in labour disputes.

Strikes in the Health Field

One of the most notable strikes in the Canadian health field was the doctors' strike of 1962 in Saskatchewan (Meillicke, 1967; Badgley & Wolfe, 1967). This was a political strike in that physicians were in dispute directly with the government over the issue of medical care insurance policy. The safety of patients is a major concern when physicians withdraw their services, although doctors usually provide some types of emergency services under such circumstances. Attitudes may well be changing in view of recent events in Ontario. Physicians in that province selectively closed down hospital emer-

agency departments as part of a protest of a public policy proposal to ban extra-billing (i.e., the practice of billing both the patient and the medical insurance system for medical services rendered) (Edmonton Journal, 1986). Serious or fatal consequences as a result of physician and hospital worker strikes are difficult if not impossible to document systematically. Moreover, overall hospital mortality rates have been observed to fall during physician strikes as a consequence of fewer elective surgical procedures (Rothman, 1983).

Five physicians undertook to study the effects of the 1982 strike by Alberta nurses in a university teaching hospital where nurses were not on strike. As 57 percent of the city's acute care beds, including 47 percent of the intensive care beds were closed by the strike, a hospital-wide plan was implemented to cope with an anticipated influx of more acutely ill patients. The plan provided for the augmentation of medical and nursing staff by some 50 percent in emergency rooms and 30 percent in intensive care units. Subjective perceptions of deteriorating care over the 23-day strike were not borne out by the parameters of care measured in this study. The number of emergency admissions, levels of acuity and death rates in intensive care units all increased, but the death rate, length of stay and number of unexpected deaths in medical units were similar to pre- and post-strike periods. The researchers concluded that admitted patients fared as well during the strike as before or after (Stabler, Schnurr, Powell, Stewart, & Guenter, 1984). On the whole, there has been little research effort directed towards measurement of the impact on health outcomes of strikes by health workers (Wolfe,

1979).

In the United States, the single most comprehensive summary of strike activity in the health field seems to be that of Rothman (1983). In that country, much interest has been shown in the effect of unions on overall hospital expenditures following the 1974 amendments to the National Labour Relations Act. These legislative changes extended coverage to private, non-profit health care institutions, and as a result, significant unionization has taken place with a corresponding rise in the incidence of strikes. Strikes in the American health care industry now occur at the same rate as in other industries (Clarke, 1983; Kruchko & Fries, 1984).

The impact of unionization on total hospital expenditures would seem to have been modest judging by experience in the United States. For example, Mulcahy & Rader (1980) report that health care wages increase on average by five percent per year once employees are unionized, but that the union effect is greater on fringe benefits, with average annual increases of 8.4 percent. Reasons given for this pattern are that unions are weak and disorganized, and that due to high rates of employee turnover, management is more willing to accede to fringe benefits demands because some benefits will never be paid. Research by Sloan and Adamache (1984) indicates that hospital expenditures in 1980 would have been no more than 10 percent lower in the absence of unions. Hospital management has been able to mount strong opposition to unions, arguing that its ability to pay higher wages is severely restricted by the system of reimbursement, particularly by third party payers. Unlike the political pressure that unions can

exert on Canadian governments, it is difficult, as Clarke (1983) suggests, for unions in the United States to apply direct pressure on third party payers. No comparable Canadian studies could be found during this literature search.

Strikes by Nurses

There appears to be no published research on strikes by Canadian nurses, although a few descriptive accounts of protest behaviour and strike activity have appeared in health care journals. Official government records indicate that between 1966 and 1982 there were thirty-two strikes by nurses. Hospital-employed nurses showed the greatest propensity to strike followed by public health nurses, then educators. Strikes occurred in all of the Canadian provinces with the exception of Prince Edward Island, with one strike in the Northwest Territories, and none in the Yukon (Labour Canada, 1966-1982).

As part of a comprehensive survey of professional nurses' associations and unions representing nurses, Jensen (1984), in her unpublished doctoral dissertation, attempted to identify characteristics of unions as predictor variables of strikes and threatened strikes. In what appears to be the only study of its kind in Canada of strikes by nurses, Jensen found little evidence in her limited sample that such variables as size and age of union could be regarded as individual predictors of either strikes or threatened strikes. In 80 percent of the strikes, wages were cited as the first priority, with other items of disagreement being shifts and scheduling of hours, hours of work, professional issues, and benefits. In addition to wages, perceived erosion of existing rights was often mentioned as

the reason for a strike.

In the literature from the United States, two surveys of strike activity among nurses were identified. Miller and Dodson (1977) extracted 103 reports of work stoppages, demonstrations, and mass resignations from the American Journal of Nursing for the period 1960 to 1974. Work stoppage was found to correlate highly with community size, and had occurred most frequently in seven states and the District of Columbia. Forty-six percent of the states had no incidence of nurses' strikes at all. The researchers discussed reference groups, imitation, contagion, and community size as possible concepts to be considered in a theory of work stoppages by professional nurses. The second survey was by Kalisch, Kalisch, and Young (1983). Recognizing the importance of media coverage as a political resource to the parties engaged in industrial disputes, these researchers investigated images portrayed by television news coverage of striking nurses in the New York area during 1980. Their premise was that positive media coverage which brings about favourable public opinion towards a party might be to the advantage of that party in a dispute. A content analysis of 229 broadcasts involving 26 separate incidents of strike and 40 hospitals revealed, among other things, that nurses were quoted or interviewed more often than hospital administrators. The investigators reported that more positive news coverage was given to nurses when they demonstrated solidarity, when they maintained this cohesion over time, and when they received the support of other health care workers. Hospital administrators were found to be the most negative in their televised comments about striking nurses.

Case studies. Strikes by nurses have been the subject of several case studies undertaken in the United States. The general approach has been to examine the attitudinal and behavioural militancy of individual nurses involved in strikes in an attempt to identify predictor variables. Several themes emerge from these enquiries. Younger nurses and those having more education were identified as being more likely than their older colleagues to have taken part in strikes in studies by Bloom, O'Reilly, and Parlette (1979), Jacox (1969) and Eberle (1982).

In a study of public health nurses by Bloom et al. (1979), younger nurses were said to be more likely to feel that the union would represent their professional interests, while older colleagues looked to their professional association as their major referent. Younger nurses did not believe that collective bargaining was incompatible with professional standards or that strikes were inappropriate for nurses. The researchers found evidence that younger nurses came from higher socioeconomic family backgrounds, suggesting that these nurses were likely to be self-directed and to see militancy as a means of bargaining with management. These results were interpreted as a change in nurses' images of professionalism.

Changes in the belief systems of nurses were of interest to both Grand (1971) and Eberle (1982). In the study by Grand, three sets of beliefs were identified as being consistent with prevailing ideologies in selected periods in the development of the nursing profession. Grand called these ideologies Nightingalism (or the service ideal); Employeeism (or the belief that the employer will do the best

for his employees); and Professional Collectivism (or the belief that the individual practitioner is responsible to improve working conditions for the long run benefit of the patients). Grand administered a questionnaire to the staff of a hospital that had experienced a 17-week strike by nurses. High alpha reliability coefficients were reported for each of the three ideology scales. The investigator found that the majority of nurses subscribed to the set of beliefs consistent with the service ideal or Nightingalism. However, those who subscribed to Professional Collectivism were more likely to have taken part in the strike, while those expressing Employeeism beliefs were more likely to have remained on the job. The significance of these results, as Grand concludes, is that Professional Collectivism allows nurses to reconcile two sets of conflicting value systems, namely a commitment to the service ideal and the pursuit of economic self-interest.

Eberle (1982) developed a theory of militancy to examine and explain nurses' participation in a 5-day "sick-out" in a university hospital. Three major conceptual areas were identified: degree of traditional nursing ideology; extent of the presence of social variables; and the degree of "anomia" (defined as the extent to which nurses feel forces beyond their control are responsible for inability to achieve goals). Her sample consisted of 216 militant and 106 non-militant nurses, i.e., those who did or did not take part in the strike. These nurses, however, were not representative of the general population of registered nurses, because they were employed in a university setting, were younger, more educated, and more likely

to be single than the national norm. Moreover, they were legally forbidden to strike. Eberle found that militant nurses were more likely to reject traditional nursing ideology and support participation in strikes, protests, and acts of civil disobedience. It was interesting to note that there was no difference between the militant and non-militant groups in the degree of belief in feminist ideology. Militant nurses were found to identify with nursing organizations which supported militant behaviour, and to receive more approval for their behaviour from reference individuals than the non-militant group. The third dimension of Eberle's theory, anomia, was not effective in distinguishing between the two groups, that is, both groups scored the same on standardized scales measuring internal-external locus of control.

Zacur (1979) undertook to study two unrelated and dissimilar strikes by nurses with a total sample of 71 respondents, constituting a 35 percent response rate to her questionnaire. The purpose of the research was to examine the case histories of the strikes, to explore the reasons why nurses chose to strike, and to assess demographic and career characteristics of nurses as determinants of nurse militancy. Zacur concluded that nurses may be more willing to strike for professional reasons than for traditional economic issues, especially when their work environment denies them a sense of professionalism. Due to the lack of methodological rigour in this study these results should be interpreted cautiously.

Levi (1980) examined the circumstances of the 1976 nurses' strike in Seattle, in which 2000 nurses walked out of 15 hospitals

for 10 weeks. Levi uses the failure of this strike to explicate her theory of the functional redundancy of nursing. Her premise is that: "Control over the labor supply coupled with monopolization of a socially significant function seems to be the sine qua non of a professional" (p. 347). Nurses, she argues, do not control the supply of labour and were thus unable to prevent hospital managers from hiring 1000 other registered nurses as strike replacements from the surplus of nurses in the area. Second, registered nurses have failed to secure a monopoly over any set of what are deemed to be socially significant (or even insignificant) roles, for when staff nurses walked off the job, much of what they did was undertaken by management nurses and other health care workers. While her argument is impressive (albeit somewhat sketchily presented here), it would seem difficult to reconcile the hiring of 1000 replacement nurses with the notion of functional redundancy. The failure of the nurses to achieve their bargaining goals, if analysed from a bargaining theory perspective, would have led to the identification of such causal factors as intraorganizational strife among union leaders, unfavourable economic conditions, and superior employer bargaining power -- an approach not pursued by Levi.

The only Canadian case study to be found was one by Milne (1986) of the 1982 strike by Alberta nurses. The purpose of this unpublished paper was to provide an historical account of the events and issues in that dispute. The author chose content analysis of public documents as her research method, and concentrated primarily on newspaper reports and press releases. She concluded that there were

three underlying problems in the dispute. First, the feasibility of a single, province-wide collective agreement was seriously implicated as a source of difficulty. Second, the dispute was said to be primarily about the demands of nurses to improve working conditions. And third, the dispute drew attention to the need for a resolution of the dilemma created by conflicting legislated rights, namely, the right of nurses to strike and the right of the public to health services.

The causes of the strikes in the case studies cited above were not the primary focus of the research, although the issues underlying the disputes and probable causes were often discussed. Union security and composition of the bargaining unit were important issues in strikes where nurses were seeking a first contract (Jacox, 1969; Grand, 1971). Economic demands featured in all of the strikes as did concerns of nurses with professional issues. Resistance of hospital administrators to collective bargaining by nurses was the most common causal factor identified in these case studies. Not unlike an observation made by Gouldner (1954), two investigators reported changes in administration and the adoption of more bureaucratic styles of management as causal factors in the strikes (Jacox, 1969; Grand, 1982). A history of militancy in the union was a factor in the study by Levi (1980). Inexperienced leadership and intraorganizational problems within the union featured in several of the strikes, and all researchers reported long-standing dissatisfactions with salaries and working conditions as causal factors. Research methods included survey techniques and document search, but it would

seem that none employed a strategic informant approach as in the case of this study.

One theme that emerges from this review of nursing studies is that most of the groups of nurses (with the exception of the Alberta group), were bargaining from a position of extreme weakness. Inexperienced leaders, management opposition, insufficient legal protection, lack of union solidarity and, in one case, a surplus of nurses in the community all served to undermine the effective pursuit of bargaining objectives. From this perspective, militancy is an understandable response to obstacles in the path of goal achievement. What has not been demonstrated is the question of whether nurses are prepared to strike in sole pursuit of professional goals, or even if professional bargaining goals are more important to nurses than economic goals.

Summary

The nature of strikes as a form of social conflict, together with selected theoretical and research approaches to strikes have been reviewed in this chapter. It was noted that most of the studies of strikes in the health care field emanate from the United States, as do surveys and case studies of strikes by nurses. A comprehensive theory of strikes at the collective bargaining level is likely to be an elusive goal, because as Gouldner (1954) and many others have remarked, strike is a complex phenomenon. Nevertheless, even in the absence of comprehensive theory, it is clear that the strike is a potent force for social change, allowing workers the potential to determine for themselves how, and under what circumstances, their services will be employed.

CHAPTER III

Method

Research Approach

In its most fundamental form, the question being raised in this study was: "What exactly was going on in this series of strikes by nurses?" This type of research question is the most elementary and, according to Van Maanen (1982), one of the most difficult to answer adequately. The nature of the question to be addressed and the manageability of the project by a sole investigator indicated that the research should take the form of an historical case study. The decision to undertake a case study was based on the following rationale.

The essence of the case study is that it is focussed upon an instance, and unless the case is selected as an instance of a class phenomena, generalizations may be made about the case, rather than to the class (Adelman, Jenkins, & Kemmis, 1980). The case study is not restricted to particular research methods and may be designed for testing hypotheses or for generating theory, therefore quantitative or qualitative research techniques may be used, or a combination of both. The case study has two principal aims according to Becker (1970). First, it permits a comprehensive understanding of a social phenomenon by addressing such questions as membership (in the case of groups), modes of activity, and patterns of interaction. The second aim is to develop theoretical statements about regularities in social structure and process. The flexibility in data gathering techniques and the ability to study the strikes in depth were compelling reasons

for choosing a case study approach.

Case studies of strikes have typically involved the investigation of a single strike, and not infrequently the strike has been of the wildcat type, that is, the spontaneous or unofficial kind. The strikes investigated in this study were all legally constituted, each occurring as an outcome of the process of contract renewal. They were not the kind of protest that emerges on the shop floor with seeming unpredictability. Rather, they were carefully contemplated within a framework of predetermined conflict resolution procedures, sanctioned by secret and democratic ballot, and lawfully executed. The series of strikes provided an opportunity to examine in depth three instances of the strike phenomenon within one collective bargaining relationship, and to make comparisons between and among them.

The unit of analysis in this study is the interorganizational relationship between a union and an employers' association. In this respect, it differs from earlier studies of nurses' strikes because they have primarily focussed on the attitudes and behaviour of nurses as individuals or groups of individuals. Explaining the causes of strikes at the collective bargaining relationship level of analysis is theoretically a complex undertaking--a point that is well discussed by Kochan (1980) in his micro model of strikes and impasses. He states:

The approach taken in developing the micro model of the causes of strikes or impasses is to recognize that while collective bargaining arises out of the conflicting economic interests of employers and employees, the negotiations process also involves political, legal, structural, organizational, interpersonal or attitudinal, and personal forces, and takes place in a specific

historical context. Impasses may be caused by pressures from any one or a combination of these components of the bargaining system. Thus, the task of a micro theory of impasses is to identify the critical variables from this interplay of forces that affect the negotiations process. (pp. 256-257)

Theories of strike activity at macro analytic levels were assumed to have insufficient explanatory power on their own when applied at the micro analytic level. Therefore, a decision was made to take a theoretical approach that required analytic induction. Data would be collected from various historical and current sources and an attempt made to generate propositions from the data. Encouraged by a statement of Glaser and Strauss (1967, p. 11) that one does not need to be a genius to generate useful theory, the investigator designed the study in such a way that the methods of grounded theory could be employed.

Grounded theory is a term developed by Glaser and Strauss (1967) to refer to the discovery of theory from data systematically obtained through social research. As a research method, it has the advantage that the people to whom the theory applies are able to scrutinize the methods of the researcher, and to understand and assess the adequacy of the notions and propositions generated (Glaser & Strauss, 1967). This type of research aims to develop a theoretical explanation which more closely fits the substantive area of inquiry, rather than to explain the phenomena under investigation through the process of verification of existing theory. An inductive approach, however, does not preclude reference to, or elaboration of, existing theories.

The development of grounded theory, like other forms of qualitative research, has been associated with the study of natural settings

and with participant observation techniques. However, qualitative research is characterized by multiple sources of data and a wide range of data collection techniques including content analysis of historical materials, field notes, and interview data (Van Maanen, Dabbs, & Faulkner, 1982). One of the problems of collecting qualitative data is that there are few traditional conventions to guide the researcher compared to those that exist for quantitative data (Miles, 1979). Also, the range of phenomena that might have theoretical relevance during the course of a social study can be overwhelming, particularly for an inexperienced researcher. For this reason it was decided that questions would be drawn up to serve as a general guide during the data collection and theoretical sampling processes.

The main question that stimulated the research, as noted above, was why the strikes occurred at all, but there were four subsidiary questions which reflected particular areas of interest. These were:

1. What were the probable causes of the strikes?
2. What, if any, were the predisposing factors in these strikes?
3. How did the participants explain the strikes?
4. What was the nature of the issues in dispute?

One question that has been the subject of considerable debate is whether or not the researcher should approach the task of developing grounded theory with an open mind and with no a priori questions or assumptions. A predetermined framework, it is argued, might impose an artificial order or logic on the observations made by the researcher. The position adopted in this study was that it would have been

an inappropriate use of the time and goodwill of informants not to have delimited the subject of inquiry during the interviews. Also, as Miles (1979) notes, the risk of having a rough working frame in place "is not that of 'imposing' a self-blinding framework, but that an incoherent, bulky, irrelevant, meaningless set of observations may be produced, which no one can (or even wants to) make sense of" (p. 119). The questions proved to be helpful in determining which of a vast array of documents to select, and the relevance of data during theoretical sampling, especially when assessing historical material.

Theoretical Sampling

Glaser and Strauss (1967) use the term "theoretical sampling" to describe the process of generating theory from data:

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory, whether substantive or formal. (p. 45)

Some practical implications of strictly adhering to the process of theoretical sampling as advocated above should be obvious. People, as sources of historical data, are not necessarily available when the researcher has reached a critical point in the analysis of data, and access to institutional records may not be extended on a continuous basis. In order to approximate the process as closely as possible, a much greater volume of data was gathered than would otherwise have been necessary, particularly documentary data. Interview respondents proved to be willing to receive follow-up telephone calls where the need for additional information or clarification became apparent.

Sources of Data

There were two main sources of data namely, strategic informants and documentary materials.

Strategic informants. Interviews were conducted with a non-randomly selected sample of men and women who played leading roles in one or more of the strikes. It was anticipated that these actors in the disputes would provide the richest source of data and the most important insights and perceptions into the causes of the strikes. Although many hundreds of people involved in the strikes might have been sampled for their individual perspectives on the subject, research economy dictated that informants be selected carefully on the basis of their experience (Selltitz, Jahoda, Deutsch, & Cook, 1959). As there appeared to be no simple rule for determining an appropriate number of informants, interviewing continued until the point at which no new information or insights were being raised.

In addition to the prominent personalities and leaders who were initially identified as critical people to interview, several people were identified by both union and management personnel as being what Sjoberg and Nett (1968) refer to as strategic informants. Such people are said to be stable marginal informants and sensitized to the normative arrangements of the parties they deal with. Many of these contacts were pursued, and subsequently the interviews with these strategic informants produced much significant new information, as well as confirmation of earlier perceptions, opinions, events, and activities, or as Miles (1979) would have said: rich, thick, earthy, and attractive data. Many of the opinions expressed were notably

unequivocal. In other cases, informants reflected on both positions in the disputes as a consequence of their marginal allegiance to the principal parties. One such informant had been an active unionist in 1977 leading nurses out on strike, but had been promoted some time later to an out-of-scope position in personnel management. A list of strategic informants with titles or roles assumed during the disputes appears in Appendix D. The dates on which the interviews took place are also indicated on this list.

The interviews were semi-structured and centered upon the particular role, experiences, and impressions of the informant. They were conducted much like conversations (Burgess, 1982) with the aim of eliciting frank and open comments, and were flexible enough to allow for the follow up of interesting ideas. All the informants were invited to explain why they thought the strikes had taken place and to give their reasons. Interviews were tape recorded where permission was granted, otherwise field notes were made during and immediately following the encounter, or, as in some cases, the telephone conversation. Transcriptions were made of all interviews, copies of which were sent to informants if requested.

Documents. A wide range of documents was gathered, searched, and analyzed. Included in this material were original negotiating demands of the parties, briefs to the government and to arbitration boards, reports, collective agreements, minutes of meetings, letters and memoranda. The employers' association made available many of its labour relations files and the 30 volumes of court transcriptions from the 1982 Public Emergency Tribunal. The union made available

back issues of its News Bulletin and selected internal files, for example, a summary of bargaining demands submitted from the local bargaining units. An opportunity was provided by the union for the investigator to review a film made during the 1977 strike for the purpose of indoctrinating nurses in the ideology and aims of unionism.

The Alberta Legislature library proved to be the most inclusive repository of newspaper clippings on all of the strikes, and contained volumes of Alberta Hansard with records of debates and question periods in the Provincial Legislature. A Member of the Legislative Assembly lent several files of internal memoranda, and many informants delved into their personal files to produce hand written notes of meetings where no official minutes existed, as well as unpublished speeches, letters, and position papers.

Extensive field notes were made throughout the document search and were indexed under three major files corresponding to the three strikes. Most of the primary sources (for example, briefs to arbitration hearings) were photocopied so that they would be on hand for content analysis during the process of theoretical sampling.

Generating the Categories

The elements of theory consist first of conceptual categories and their properties, and second, of hypotheses or generalized relations among the categories and their properties (Glaser & Strauss, 1967). The term "conceptual category" refers to abstraction from the data, or, in other words, a concept that is indicated by the data but which is not the data themselves. For example, a series of

anecdotes narrated by one union leader suggested a pattern of risk taking behaviour that was initially labelled "opportunism." Thus, a category had been teased out of the data.

The next step is to saturate the categories until it is clear what further instances would be located in this category (Turner, 1981). The categories may stand alone, or they may have certain conceptual aspects of their own referred to as "properties." For example, when questioned about certain courses of "opportunistic" behaviour, one union leader replied: "Well there is always a chance that you might win" (Robert Donahue, personal communication, October 29, 1983). Thus, the reason given for challenging anything perceived as a barrier to goal achievement was that there was a "chance of winning." Chance of winning became identified as a categorical property of "opportunism," and because such categories and their properties appeared to have theoretical relevance for the research question, more instances were sought in order to firm up these emerging elements of theory. A process of constant comparison was followed, coding instances and comparing them with like and unlike categories (Glaser & Strauss, 1967). In this way, themes were drawn from the data by integrating the categories and their properties, and developing notions and propositions. Such propositions are the rudiments of substantive theory or theories of the middle range, as distinct from formal or grand theory (Merton, 1949).

The process described above requires not only theoretical sensitivity to the data, but an ability to code, organize, and manipulate them in ways that reveal new elements of the theory. The

practical aspects of such a process have been discussed by Turner (1981), whose scheme for developing two sets of records and nine stages of grounded theory was used as a model. As categories were identified, the provisional title was written on a 5 by 8 inch index card, and as more instances were identified and noted on the card, the title was modified to ensure the goodness of fit between data and category. Finally, a definition of the category was stapled to the index card, outlining the general criteria for putting further instances into the category (Turner, 1981). This was a time consuming and labour intensive process in which the researcher became totally immersed in the raw data. A tracer scheme was devised in the coding system because the process of constant comparison seemed to require that the context of an instance or property be referred to from time to time. Quick reference to the exact place in a document or interview transcription was made possible, precluding a great deal of shuffling and searching through an enormous quantity of paper. Moreover, it was easier to pick up the threads in the process after periods of absence from the task.

Theoretical sampling and the process of constant comparison was followed for each strike individually using a three colour index card system, that is, white cards for the 1977 dispute, pink for 1980, and gold for 1982. Subsequently comparisons were made across the three sets of index cards to identify the common or unique themes. For example, the theme labelled 'the worth of the nurse' was clearly evident in all three disputes and pertained to the feeling among nurses that they were worth more than they were being paid. Common

and unique themes, once identified, were entered on a fourth set of green index cards by title and number of card to facilitate the rapid location of a particular datum, and for cross reference purposes.

Preliminary Research Activities

Access to Agencies

Letters were sent to the United Nurses of Alberta (UNA) and the Alberta Hospital Association (AHA) outlining the proposed research and requesting their participation in the study. A letter of agreement was received from the AHA, and subsequently, a memorandum was sent out from the AHA to all member institutions, introducing the researcher and notifying them of the decision of the Board of Directors to participate in the study. Copies of this correspondence can be found in Appendix E. The President of the UNA gave a verbal commitment by telephone to participate in the study.

As a member of the Alberta Association of Registered Nurses (AARN), the researcher was given access to the microfilmed records of all minutes of Association meetings and various reports dating back to the inaugural meeting of 1916. The history of the employee relations program of the AARN could thus be traced from the mid-1940s up until 1977 when the collective bargaining division seceded to form an independent trade union. At the time of that separation, all of the current records of the collective bargaining program were transferred to the new organization and, according to the President, they could not be located for examination (Margaret Ethier, personal communication, September 23, 1983). The investigator depended substantially on the cooperation of individual union members to

recover material relevant to the early days of the UNA from their personal files. In addition, the University of Alberta Hospitals Staff Nurse Association (a union unaffiliated with the UNA) agreed to provide access to its historical records.

Chronologies of the Strikes

The task of the investigator initially was that of an historian, assembling relevant documents and subjecting them to the principles of historical criticism (Hockett, 1955). In general, verification of authorship was not difficult, but evidence of dates and other details was at times incomplete or entirely missing. A decision was made to compile a chronology for each of the three disputes and these appear in their final form in Appendices A, B, and C.

The chronologies served several useful functions. Formulating them seemed to be a necessary first step in orienting the investigator to the complex circumstances of each dispute. It assisted in the identification of individual actors who played significant roles in the strikes, and who later were approached to be interviewed. The chronologies were expected to be of interest and assistance to prospective informants, because many of these people would be asked to recall their views and impressions of events that had occurred some two to seven years earlier. The information contained in the chronologies was carefully restricted to the basic facts of names, dates, events, and issues, and was clearly not intended or expected to influence the perceptions or attitudes of the informants about those basic facts. Various union and management people reviewed the chronologies, questioning and verifying the contents -- a process

which served to increase the trustworthiness of the information.

Limitations of the Study

The study is limited in several ways. The decision to undertake an historical case study limits the findings and conclusions to the experience of nurses and employers in Alberta. The research question might have been addressed through a comparative study province by province, but such an undertaking was considered to be beyond the scope and resources of the researcher. An inter-provincial comparison of strikes by nurses might well be attempted in the future, in which case it is hoped that this study will provide valuable information.

Second, many of the actors interviewed still play prominent roles in the Alberta labour relations and health care systems. The investigator has a moral and ethical obligation to consider the consequences of reporting certain perceptions expressed that clearly infringe on a person's privacy or that have the potential to interfere with his or her current responsibilities. Despite their relevance to the research problem, the researcher must find a balance between these legitimate concerns and the search for scientific truth. All of the leading actors are identifiable in this report, but direct attribution by name has sometimes been avoided. For the most part, permission was given by the informants to quote them freely. It is of interest to note at this point that not one person contacted refused to be interviewed.

Third, the understanding that emerges from this research is a product of the interaction between the investigator's particular

background and competence and the phenomena being examined (Turner, 1981). This researcher was neither a sociologist nor an expert in the field of industrial relations but had the temerity to undertake an inquiry that would have benefitted from the expertise of both. This is a problem faced by many potential researchers interested in the social aspects of their particular disciplines. In this case, the problem was partly offset by the investigator's ability to bring to the inquiry a varied background of experiences both as a staff nurse and as a health care administrator. However, during the first two disputes, the researcher held a position as a senior administrator in a 364-bed provincially owned hospital in Alberta. Although the nurses in that hospital were restricted by the legislation governing public employees from withdrawing their services, the researcher was an ideological participant in the provincial labour picture throughout the period under study, and readily identifiable as belonging in the management camp. Undoubtedly such factors influenced to some degree the gathering and analysis of information and other phases of the study. The possibility of bias was constantly considered by the researcher, but whether such bias is discernible in the analysis and conclusions of the study remains a question for the reader to decide.

Attention is now directed to some historical antecedents to the six-year period under study, in particular, the social and political context of labour relations in the Province of Alberta.



CHAPTER IV

The Environmental Context of Labour Relations in Alberta

The purpose of this chapter is to provide an overview of the environmental context of labour relations in the Province of Alberta. It has been said that the study of labour relations in Alberta is inevitably a study of pluralism on account of the multiculturalism of the people, and the diversity of both the ecology and the economy (Tidsbury, 1978). The labour disputes under investigation occurred during an economic boom in the province, and because of the importance of economic factors in the incidence of strikes, a description of selected social, political and economic trends contributing to the 1977-1982 era of the province's history is provided here. A brief account of the health care system and its funding arrangements is followed by an overview of the legal framework and its role in the management of labour conflict in the health industry.

Ecological and Social Factors

Alberta became a province of the Dominion of Canada in 1905. It is the fourth largest province both in land mass and population, and has one of the most varied of landscapes including mountains, forests, lakes, prairies, and semi-desert areas.

At the turn of the century, Alberta's population was sparse, consisting mostly of native peoples and settlers from eastern Canada, the United States and Europe. During the first two decades, migrants and immigrants moved into the province in great numbers establishing homesteads and setting up businesses. These people were from wide ranging ethnic, racial, social, and religious backgrounds (Hardy,

Johnson, & Hampson, 1967)). By 1982, Alberta had a population of approximately 2.3 million people distributed unevenly around the province, with two large concentrations in the metropolitan areas of Edmonton and Calgary. The population of each of these cities was close to half a million people (Alberta Statistical Review Annual 1982, 1983).

The Distribution of Hospitals

The first hospitals in the province appeared in the southern half, along the main supply routes from the east and the trans-Canada railway. These early hospitals were owned by voluntary and religious groups and were operated as charitable organizations. As might be expected, the greatest concentration of hospitals providing all types of care is now to be found in the two metropolitan areas of Edmonton and Calgary.

At the time of the first nursing strike in 1977, there were 159 general and auxiliary hospitals and 77 nursing homes in Alberta. An auxiliary hospital is one which provides skilled nursing services and medical care to chronically ill or disabled patients, usually over an extended period of time. A nursing home provides general health care supervision to residents no longer able to live independently in their own homes. A summary of hospitals and nursing homes according to ownership is presented in Table 3. It will be seen that at the end of December 1977, there were 15,137 adult and pediatric hospital beds (not including newborn cribs) providing a ratio of 8 beds per 1000 population. The Canadian average ratio at the time was 7.1 beds per 1000 population (Alberta Hospital Services Commission, 1977). In

Table 3

Alberta General Hospitals, Auxiliary Hospitals, and Nursing Homes by Ownership as of December 31, 1977

Type of Ownership	General Hospitals	Beds	Auxiliary Hospitals	Beds	Nursing Homes	Beds
District and Municipal	96	6803	20	1894	31	2100
Voluntary, Religious and Lay Corporations	22	2128	9	949	11	1239
Provincial Government	5	2474		40 ^b		
Federal Government	7	669		180 ^b	1	150
Private					34	3536
Total	130 ^a	12074	29	3063	77	7025

Note. Compiled from data contained in the Annual Report for the nine month period ending December 31, 1977.

Alberta Hospital Services Commission.

^a Includes two special rehabilitation centres, two federal nursing stations, and one contract hospital.

Excludes two mental hospitals operated by the Department of Social Services and Community Health.

^b Extended care beds operated by public general hospitals.

addition the nursing homes were operating a total of 7025 beds.

The general hospitals in the province are listed according to size of bed complement in Table 4. It will be seen that nearly half of all active treatment beds were operated by seven of the largest hospitals. These seven hospitals are located in the large urban centres and are affiliated with universities. One hundred hospitals each operating fewer than 100 beds are scattered around the province, some of the smallest being located in remote areas.

Utilization: Hospitals and Nurses

Aggregated indicators of hospital utilization in the province generally reveal an interesting pattern. Alberta has provided a higher ratio of hospital beds per 1000 population compared to many other Canadian provinces, and Albertans have been disposed to use their hospital facilities at a higher rate (Bennett & Krasny, 1981). At the same time, average occupancy rates are well below the Canadian average, and so is the average length of stay in hospitals (Alberta Hospital Utilization Committee, 1981). Thus, although Albertans are admitted more frequently to hospital, they tend to stay there for shorter periods of time. Composite occupancy figures can be rather misleading because the large metropolitan hospitals operate at rates that often exceed 95 percent occupancy while lower occupancy rates are found in rural hospitals. Many of Alberta's numerous small, rural hospitals operate at less than 65 percent occupancy. Complex cases are generally referred by them to specialists in the urban hospitals, and subsequently transferred back to the local hospitals for convalescence.

Table 4

General Hospitals in Alberta by Size: December 31, 1977

Adult and Pediatric Beds	General Hospitals	%	Total Beds	%
1 - 24	26	21.0	386	3.3
25 - 49	54	42.9	1820	15.6
50 - 99	26	21.0	1616	13.9
100 - 299	12	9.5	1995	17.1
300 and over	7	5.6	5844	50.1
Total	125 ^a	100.0	11661	100.0

Note. From Alberta Hospital Services Commission, Annual Report for the nine month period ending December 31, 1977.

^aExcludes two rehabilitation hospitals, one contract hospital, and two federal nursing stations providing ambulatory services.

The Alberta Hospital Utilization Committee (1981) was appointed to study and advise the Minister of Hospitals and Medical Care on a broad spectrum of issues related to hospital utilization: "With special emphasis on the number of surgical procedures being performed in Alberta hospitals" (p. 1). The Committee's report was inconclusive with respect to rates of surgery, but staffing patterns as measured by paid hours per patient day were reported as being below the Canadian average for active treatment hospitals and the lowest for extended care hospitals of eight provinces reporting" (p. 5). Moreover, the per diem cost per patient for hospitalization was also

below the Canadian average. These rather limited findings seem to suggest that despite higher than average utilization rates, hospital services at that time were provided efficiently. However, an alternative explanation might be that hospital employees were more productive than their counterparts elsewhere and less generously reimbursed.

The variability in utilization patterns across the province constitutes one of many factors contributing to disparities in the working conditions of nurses. The work settings themselves differ in terms of size, location, types and levels of patient care, management policies, practices, and leadership styles, to mention but a few of the variables. Moreover, the nursing care requirements of patients in small rural hospitals are apt to differ significantly from the requirements of patients admitted to 1000-bed tertiary care centres.

In rural hospitals, nurses have historically been expected to turn their hands to a wide range of tasks, not all of which require the skills and knowledge of a registered nurse. Conversely, nursing tasks sometimes require skills and knowledge that exceed the educational preparation of the average registered nurse. For example, it is not uncommon for nurses to suture lacerations or to deliver babies in the absence of physicians. The same nurse may also be expected to answer the telephone for the local fire brigade, dispense drugs, and perform housekeeping functions in addition to providing direct nursing care to patients.

In contrast, the work of nurses employed in large, metropolitan hospitals is of a different pace and scope. Patient care require-

ments are generally more complex, specialized, and intensive, and the work setting is characterized by fluctuating workloads, rapid patient turnover, changing technology, automated support systems, and a multidisciplinary workforce. When such heterogeneous organizational entities and their respective employee associations join forces for collective bargaining purposes, the issues and demands brought to the negotiating table are likely to be as diverse as the work settings themselves.

Economic Factors

The economic history of Alberta is an intriguing rags-to-riches story. In the early part of the century the province's economy was underdeveloped, being primarily agrarian with more than half of the labour force engaged in agriculture up until 1941. Following a major oil field discovery in 1947, the province embarked on a period of unprecedented economic expansion. Millions of dollars of investment capital poured into the province over the next twenty years, creating thousands of new businesses and jobs to service the oil industry (Caldarola, 1979). By 1971, the size of the labour force engaged in agriculture had dwindled from one half to one eighth, and although all sectors of the economy had experienced labour force increases, the greatest increases occurred in government, trade, and the service sectors (Masson & Blaikie, 1979).

Women have played a significant role in the expanding economy, entering the workforce in increasing numbers. In 1979, Alberta had the highest labour force participation rate for women in Canada, with 54.6 percent of its women in paid employment compared with 48.9

percent for Canada as a whole (Alberta Statistical Review Annual 1982, 1983). Another indicator of the economic state of Alberta was its unemployment rate which, for the first four years of the study period, remained at approximately one half the national unemployment rate. However, in 1982 the economy began to slow down and the unemployment rate in the province almost doubled from 3.8 percent in 1981 to 7.5 percent in 1982. By 1982, the total labour force in the province had reached 1.16 million persons, having almost doubled in a period of eleven years (Alberta Statistical Review Annual 1982, 1983).

One of the most widely discussed indicators of Alberta's prosperity, wealth, and rising status on the Canadian national scene was the establishment of the Alberta Heritage Savings Trust Fund in 1976. The principal purpose of the fund was to set aside a certain amount of the revenues being received from the sale of the province's non-renewable resources for the future benefit of Albertans (Alberta Heritage Savings Trust Fund, 1977-1978). Monies from the fund were to be spent to improve the quality of life in Alberta; to strengthen and diversify the economy; and to provide a source of investment income. In 1977 the fund amounted to \$2 billion, and by 1982 it had grown to \$11 billion (Alberta Heritage Savings Trust Fund, 1981, 1982). The provincial government drew substantially from this fund to support certain hospital renewal projects, thereby using the fund as a supplementary source of monies already earmarked for an ambitious \$2 billion hospital capital construction program announced in 1980.

Inflation

The decade of the 1970s was notable for its rapidly rising inflation which stimulated a country-wide escalation in the cost of living. For the individual Albertan, it was a time of great employment opportunities, growth in personal income, and rising expectations. By 1981, this trend reached a peak because, for the first time in Alberta's economic history, the average personal per capita income for the province was the highest of all provinces at \$12,777, compared with the Canadian average of \$11,520. A registered nurse as a beginning practitioner earned a base salary of \$471 per week compared with the average Albertan earning \$435 per week. At the time, this minimum salary rate for registered nurses in Alberta represented the second highest in Canada, second only to the salaries of nurses in British Columbia (Canadian Nurses Association, 1983).

Control over inflation became a leading political issue as the annual rate of inflation during the 1970s fluctuated between 11.7 and 15.7 percent, per annum. Employees attempted to protect their purchasing power through increasingly militant collective bargaining, and union wage settlements not infrequently exceeded 15 percent, per annum (Reid, 1982). After considerable prevarication, the federal government announced a wage and price controls program in October, 1975, to take effect over the next three years. The effect of the anti-inflation legislation was to impose strict limits on wage increases right across the occupational spectrum. Wage increases were restricted to eight percent in 1976, six percent in 1977, and four percent in 1978. An anti-inflation board was established to

monitor the program; with power to roll back wage increases that exceeded the guidelines. The Government of Alberta entered into an agreement with the Liberal Government of Canada to comply with its anti-inflation policies.

The response of the labour movement to the wage and price controls was predictably negative, and a nation-wide day of protest was staged on the first anniversary of the announcement of the anti-inflation program. Nevertheless, the controls were partly successful in achieving their primary goal of reducing inflation, according to Reid (1982). The anti-inflation program became a major stumbling block in the nurses' 1977 dispute.

Health Care Funding

The impact on hospitals of inflation in the 1970s was only one of many fiscal problems besetting the health care system. Health care funding in Canada is a shared endeavour between federal and provincial levels of government. Under the constitutional division of powers, health care was deemed to be a provincial responsibility, but the federal government's interest in the standardization of health and medical services to all Canadians led eventually to cost sharing arrangements between both levels of government in the late 1940s. However, certain conditions had to be met before federal funds were contributed to the provincial health care systems. With the passage of the Hospital Insurance and Diagnostic Services Act in 1957, the federal government had laid the first major plank on which the national health insurance system was to be built. The cost sharing arrangements between federal and provincial governments at

this point was on a fifty-fifty basis (Soderstrom, 1978).

The ideology underlying the Canadian health care system is well summarized by Lee (1975) as follows:

The national insurance program in Canada is based on the established policy that every citizen has the right to adequate health care and it is the government's responsibility to assure that right. The four basic principles of the program are:

1. universal coverage; 2. comprehensive benefits; 3. portability of benefits; and 4. public administration and accountability.
- (p. xxi)

It would be hard to find four principles of public policy that have as much popular support as these embedded in the Canadian national health insurance program. They have been repeatedly re-affirmed in study after study as well as in the recent Canada Health Act of 1984. There are, however, wide differences of opinion as to how the system should be implemented and financed.

The concerns of politicians over the rising costs of health care in the last two decades are legion, and have given rise to a series of task forces, inquiries, and studies at federal and provincial levels of government. Annual expenditures on health care in Canada in recent years have represented approximately 7.5 percent of the Gross National Product rising to 8.4 percent in 1982 (Angus, 1984). This rate of health care spending is less than is spent in the United States of America, but rather more than is spent in most European countries (Maxwell, 1975). The primary causes of rising health care expenditures include: expansion of services; new technologies; inflation; increasing salaries and fringe benefits for employees; and various factors associated with physician practices and medical reimbursement (Bennett & Krasny, 1981).

In a move to control its share of health care expenditures, the federal government abandoned its fifty-fifty funding arrangement with the provinces in 1977, replacing it with a more complicated formula known as Established Programs Financing (EPF). The Economic Council of Canada (1982) explained the rationale as follows:

Based partly on per capita cash transfers and partly on tax point transfers, [EPF] was to provide the provinces with an incentive to keep the cost of health care programs down, to make for greater equality among provinces in per capita terms, to maintain the standards achieved, and to facilitate their improvement by allowing greater flexibility. (pp. 68-69)

In essence, the federal government was attempting to stem the open-ended flow of monies to the provinces that had occurred under the first formula, which meant that the provinces would no longer be able to count on dollar for dollar federal contributions when introducing new health care programs.

In Alberta, the responsibility for administering health care legislation and the funding of hospitals and medical care was delegated to two commissions. These commissions served as intermediaries between the hospital system and government. However, following the 1977 changes in fiscal arrangements with the federal government noted above, these two commissions were dissolved and incorporated into the newly created Department of Hospitals and Medical Care. The effect of this change was to allow more direct government control over the financing, operating, and capital expenditures of hospitals and nursing homes, as well as over medical disbursements. Commenting generally on the abolition of hospital commissions, Glaser (1980) observed:

The result everywhere has been reliance on government for funding hospital costs, either through general revenue or through insurance machinery that comes close to full governmentalization. But the result is not a government hospital service The hospitals are not owned by the governments that provide the money, and the hospital workers are not employees of those governments. The hospitals are owned by private associations or by municipalities, with governing boards between them and the provincial governments. The doctors are not salaried employees of hospitals or governments; they have contracts with hospitals and are paid by fee-for-service. (p. 10)

These remarks accurately describe institutional relationships between hospitals and the provincial government in Alberta during the study period.

Political and Legal Factors

Federal-provincial relations in Canada have been dominated by the two most populous provinces, Quebec and Ontario. Alberta is one of four western provinces, and its politics have undoubtedly been influenced by a general sense of alienation from federal power and decision-making based in Ontario, or more specifically in the capital city of Ottawa. Historically, western Canadians have perceived their interests to have been subordinated to those of eastern Canadians, especially in matters involving transportation, communication, agricultural marketing, and more recently, in national energy policies.

One of the peculiarities of Alberta politics is its consensus voting patterns. Throughout its history, the provincial legislature has generally been ruled by a single party enjoying a large majority in the house, with little to fear from the official opposition. Long, repetitive cycles of maintenance elections have been the general rule (Elton & Goddard, 1979). In 1971, the Progressive

Conservative party replaced the Social Credit party, and has remained in power ever since. In the 1975 provincial election, the Progressive Conservative party was returned to power with an overwhelming majority of 69 seats in the 75-seat legislative assembly, and with not only a small, but a divided opposition. Such a mandate represents a formidable amount of power to be vested in a government, albeit a democratically elected one.

The Union Movement

Organized labour in Alberta has not played a major role in the province's political history. It is interesting to note that in a survey of union members in 1971, the respondents reported that although they thought the New Democratic Party was the party likely to do most for the union movement, they voted overwhelmingly for the Progressive Conservatives, as did the rest of the electorate (Masson & Blaikie, 1979).

Alberta is not particularly noted for the militancy of its unions; moreover, a relatively low percentage of its labour force is unionized. In 1977, for example, union members comprised 26 percent of the non-agricultural paid work force compared to 38.2 percent for Canada as a whole (Statistics Canada, 1981). It is not surprising to find, then, that organized labour has been moderate in its demands on the whole. Masson and Blaikie (1979) make the following observation of labour politics in the province:

In the last twenty-five years, the province's labour force has neither been plagued with low wages nor with a substantial rate of unemployment, conditions which are generally considered conducive to militant unionism. In addition, both the Social Credit and Progressive Conservative governments have been able to develop relatively progressive social programmes while at the

same time maintaining the lowest tax rate in Canada In short, the argument is that labour has been seduced by high wages and the prospects of continued prosperity. (p. 287)

Labour Legislation

Responsibility for industrial relations in Canada, as for health care, is decentralized under provincial jurisdiction. This means that in addition to the federal labour code which governs federal employees and various national and interprovincial enterprises, there are ten sets of provincial labour laws. Despite this multiplicity of labour statutes many similarities across the various jurisdictions exist and, in general, Canadian union-management relations are characterized by a high incidence of legal intervention (Carter, 1982). Alberta would seem to be no exception in this regard.

The vast majority of labour relations in Alberta is regulated by one or other of the two principal labour statutes, each having its own administrative board which oversees the implementation and interpretation of the law. Government, crown agencies and their respective groups of employees are subject to the provisions of The Public Service Employee Relations Act (1977), which means that the seven provincially owned hospitals conduct their union-management activities according to this act. The remainder of the hospitals and nursing homes, while publicly funded, enjoy the same rights accorded to private industry and are governed by the provisions of the second statute, The Labour Relations Act (1980), which replaced The Alberta Labour Act (1973). The Public Service Employee Relations Act remained in effect throughout the six-year study period, however The Alberta Labour Act (1973) was in effect for the first two disputes,

while The Labour Relations Act (1980) applied in the case of the third nurses' strike.

The Public Service Employee Relations Act, 1977. As its title suggests, the Public Service Employee Relations Act (PSERA) sets out terms and procedures by which the government bargains with its own employees. The provincially owned hospitals can be described as crown agencies, operating at arm's length from the government under the authority of independent boards of trustees. There is virtually no operational difference in the corporate responsibility, scope of decision-making, and source of funding between the government owned hospitals and all other hospitals and nursing homes, but ownership determines the applicable labour statute for collective bargaining purposes. Two features of the PSERA are of significance to the events under investigation, one being the prohibition of strikes and lockouts, and the other being the restrictions placed on arbitral decision-making.

There are no limits as to the scope of issues that the parties may discuss during their negotiations but the law curbs the freedom of the actors at the point of disagreement. Mediation services are available for the assistance of the parties in their attempts to resolve disputed issues, but if an impasse is reached there is no other recourse except to submit the dispute to an arbitration board. Whatever the decision of the arbitration board, the parties are bound to abide by it for the term of the contract thereby imposed on them. Not only are the parties denied the usual weapons for inflicting economic injury on each other, but they are limited in the scope of

issues that can be dealt with by an arbitrator. The arbitration award, for example, must not contain decisions with respect to the organization of work, recruitment or promotion of personnel, job descriptions, or anything to do with pensions. Thus, if the employer can successfully resist union demands at the negotiating table, he has no reason to fear the erosion of certain key management rights in the arbitral process.

The Alberta Labour Act, 1973. Unlike the PSERA, there were no restrictions in the Alberta Labour Act (ALA) with respect to economic sanctions during negotiations, nor on the issues that might come before an arbitration board. Under this Act, the parties were not entitled to strike or lockout during the term of an agreement, but as soon as the contract had expired and the mandatory procedures observed (including official notification of intent to withdraw services or to close down a hospital), economic sanctions were permitted, even by hospitals and their employees. Section 163 of the ALA allowed government intervention and the declaration of a public emergency in the event of danger to life or property as a result of "a stoppage or impending stoppage of hospital services in any part of Alberta" (ALA, 1973, s. 163, 1(a)(ii)). The application of this section of the Act required the parties to cease and desist their sanctions, to restore their services, and to submit the dispute to an appointed arbitration board.

The Labour Relations Act, 1980. After extensive revisions in 1980, the ALA was replaced by two statutes, The Labour Relations Act (LRA) and The Employment Standards Act (1980). These revisions did

not alter the main differences noted above that existed between the two laws governing public sector and private sector labour relations. The mandatory procedures that had to be exhausted prior to a strike or lockout were relaxed somewhat, but the Minister of Labour was given a more prominent role to intercede in the event of faltering or obstructive bargaining. For instance, Section 93 of the LRA permits the Minister to refer an actual or potential impasse to a Disputes Inquiry Board selected by him, one effect of which is to give all parties more time to reconsider their options and positions. A Disputes Inquiry Board is empowered to make recommendations as to how the conflict can be resolved, but its recommendations are not binding on the parties.

The parties to province-wide collective bargaining in the hospital industry, then, have two labour laws to contend with, but the most controversial aspect of these circumstances is the restriction on strikes and lockouts in the provincially owned hospitals. From the point of view of the nurses' union, nothing much could be more inequitable than to allow some of its members to strike in pressing their demands, and not others. Hospital boards and management personnel tend to be divided on this issue. Although total bans on hospital employee strikes exist in Ontario, Newfoundland, and Prince Edward Island, personnel experts recognize the sacrosanct nature of the strike weapon in trade union ideology. Believing that more harmonious labour relations would ensue, some administrators favour a middle-of-the-road position that would allow for limited strikes but safeguard a minimum of emergency and critical care

services (Robert Heise, personal communication, August 17, 1983).

The unequivocal position of the Alberta government in limiting the bargaining power of its own employees has attracted considerable criticism from the union movement. This criticism has intensified since the introduction of Bill 44 in 1983, the objective of which was to amend several of the labour statutes in effect at the time (Labour Statutes Amendment Act, 1983). The main thrust of Bill 44, coming hard on the heels of the 1982 nurses' dispute, was to remove the right to strike from all employees throughout the hospital industry. The Alberta Union of Provincial Employees, in its campaign of opposition to PSERA and Bill 44 has turned to the International Labour Organization to publicize its opposition to the "repressive" labour laws of Alberta, arguing that the provincial government is violating international labour laws and conventions which Canada as a nation supports (Moysa, 1984). The Alberta Union of Provincial Employees also argues that to deny employees the right to strike is a violation of the Canadian Charter of Rights (Livingstone, 1983). These issues remain the subjects of investigation and litigation.

The combined effect of the public and private sector labour laws in the hospital industry (before Bill 44), represented a compromise between the public interest and its right to continuous hospital services, and the employees' interest and right to take collective action in pursuing their socioeconomic demands. It assured the public of a minimum of hospital services in the event of massive and widespread job action, and it recognized the right to strike for the majority of hospital employees. Essential or critical care services

would at least be available at the seven government owned hospitals, notwithstanding the enormous workload implications to their staff should patients be transferred in from hospitals affected by strikes. The ability of such overburdened facilities to respond to any kind of human disaster was an ever-present anxiety to those caught up in the conflicts, but decision-makers were prepared to take such risks in resisting opposition at the bargaining table. The parties knew that they could paralyze the hospitals where the ALA and the LRA provisions applied, but that Albertans would not be entirely bereft of essential hospital services. To what extent this situation entered into the decision-making of the actors to strike, or to take a strike, would seem to be a question to keep in mind when considering causal factors.

Labour boards. The existence of legislation that governs in differing ways the public and private sectors of the economy means that the parties have to deal with two separate and independent administrative bodies, the Public Service Employee Relations Board and the Labour Relations Board, formerly the Board of Industrial Relations under the ALA. These boards function as quasi-judicial tribunals each having very similar objects and responsibilities. Traditionally, appointees to these labour boards have included experienced practitioners from both union and management camps as well as representatives from the legal profession and labour relations experts (Tidsbury, 1978). These boards serve as referees in the labour relations system, interpreting the laws, ensuring that the actors in the system observe the procedural rules laid down, and

making decisions.

In the event of a strike or lockout, the Labour Relations Board is responsible for supervising strike votes, and among other things, will investigate any complaint that it receives from one actor in the system about another. The decisions of the labour boards are final and binding on the parties with few exceptions. The existence of two labour boards in the province has been criticized for artificially fragmenting the jurisdiction for labour relations matters (Melnik, Fisher & Williams, 1982). Where the parties to collective bargaining are dealing with two administrative tribunals, there is potential for manipulating the system to gain tactical advantages, particularly during the course of protracted negotiations. For example, settlements achieved through the use of the strike weapon under the LRA would almost certainly be reflected in subsequent arbitral awards made under the PSERA, and vice versa.

At this point, it is worth noting that governments are apt to play many roles in systems of industrial relations. Not only do they make the rules by passing labour laws, but they may provide for their intervention in disputes between principal parties to collective bargaining, thus serving as a type of referee. The government also has a role as guardian of the public interest ensuring that the rights of various participants in the labour relations system are protected, and that innocent bystanders are not harmed by the fallout from industrial conflict. The government also supplies research and educational services, and perhaps most significantly, the government itself is an employer and hence, a principal actor in the

system. As Melnyk, Fisher, and Williams (1982) observe, these five roles as regulator, intervener, custodian, facilitator, and employer cast the government in a very prominent place in the system of labour relations.

Summary

The environmental context of labour relations in the province has been described to provide an historical background from which to understand the circumstances that are the subject of this inquiry. The socioeconomic and political fortunes of the province were significantly altered by the discovery of vast reserves of oil and gas shortly after the Second World War. Phenomenal economic activity took place during the 1970s drawing people and investment money into the province; this activity coincided with an accelerated national economy and rapidly rising inflation. Alberta has been governed by long-standing, right-of-centre political parties with little or no real opposition in its Legislature. The labour movement has been neither militant nor sufficiently organized to resist the restrictions on collective bargaining in the public sector which deny government employees the right to strike. The province is well supplied with hospital services compared with Canada as a whole, despite the dispersion of its population.

The Alberta Hospital Association played a central role in the development of health services in the province. As a principal actor in the nursing disputes, its origin, goals and structure are discussed in the following chapter.

CHAPTER V

The Alberta Hospital Association

Origin of the Association

The year 1919 was a significant one in the history of the health care system in Alberta. During that year, the Liberal government of the time established a Department of Public Health giving it jurisdiction over the supervision of hospitals. There were 49 approved hospitals in operation and all were receiving government grants to offset their general operating expenses (Juzwishin, 1980). With the growing involvement of government in the financing of hospital services, and the emergence of common problems among hospitals, it became apparent to hospital superintendents and senior staff that the time had come to organize an interest group. The inaugural meeting of the Alberta Hospital Association (AHA) was held in October of 1919 (Agnew, 1974).

Two years earlier the provincial government had passed the first of two municipal hospital acts permitting the establishment of hospital districts, and the development of hospitalization schemes to meet the requirements of the developing rural communities. The first municipal hospital was opened in 1919, and by the early 1930s, 21 municipal hospitals had been established (Bow, 1935). Representatives of the municipal hospitals evidently considered that their interests and problems were sufficiently distinct from those of the voluntary hospitals to form a separate interest group. Accordingly, in 1920 they organized themselves as the Alberta Municipal Hospital Association (Agnew, 1974).

These two hospital associations served their respective constituencies independently for over twenty years. Although all hospitals in the province received a per diem rate from the provincial government irrespective of ownership, the municipal hospitals had additional powers to raise funds through local taxation. In the mid-1930s, 60 percent of Alberta's population resided in rural areas (Bow & Cook, 1935), providing the municipal hospital boards with a broad basis of power within the hospital system. Amalgamation of the two organizations was considered from time to time but, according to Juzwishin (1980), failure of the two associations to achieve unity was primarily due to: (a) The Department of Public Health which encouraged the independence of the municipal hospitals in order to maintain control over them; and (b) The Alberta Municipal Hospital Association which felt that it had a separate identity to maintain. In 1936, the AHA and the Alberta Municipal Hospital Association began to hold joint annual conventions, and after many efforts to join forces, they amalgamated in 1943.

Even so, the municipal hospitals insisted on retaining their own section within the newly formed Associated Hospitals of Alberta (Juzwishin, 1980). In 1966, the association reverted to the title Alberta Hospital Association (Agnew, 1974), but the formation of coalitions among member institutions based on size and interests seems to have been an enduring characteristic of the organization. In 1960, for example, the AHA approved the formation of the Council of Metropolitan General Hospitals for those member institutions having more than 180 beds. The impetus for the development of such

an interest group arose because the larger hospitals considered they had unique problems which were not being adequately addressed by the Association (Juzwishin, 1980).

The gap between the interests of large and small hospitals within the AHA appears to have widened over the last twenty-five years, making the task of serving a diverse membership more difficult and politically sensitive. The special problems of small modern rural hospitals have been well documented in a recent AHA presidential paper (Rall, Nothcott, & Pals, 1982). Among other things, they experience difficulty recruiting and retaining specialized personnel; emergency services, and services to the elderly and long term care recipients are inadequate; patterns and rates of utilization are uneven; and hospital boards report a lack of political power. Numerically, small hospitals having less than 100 beds comprise an impressive majority of the hospitals in the province, but they command a small minority of the beds, and they consume less than 25 percent of the monies spent by the provincial government on hospital services.

The Goals of the AHA

The initial aims of the AHA, according to Agnew (1974) included:

The standardization of every hospital and training school for nurses in Alberta, and the securing of increased provincial government grants and subsidies in order to obtain better facilities, especially for the aged, the tuberculous and those suffering from chronic diseases. (pp. 79-80)

In addition to these general goals, it was the intention of the AHA to serve as a means of inter-institutional communication, cooperation, and mutual support, and to deal with common problems and issues

as they arose from time to time.

The amalgamation of the two hospital associations took place as World War II was entering its final phase. At that time, Alberta hospitals were facing a severe shortage of nurses as well as a great need to upgrade many of their facilities. The efforts of the newly constituted Association were directed towards promoting better standards of hospital services and stimulating hospital development. Probably the most important challenge confronting the AHA was the problem of hospital funding.

The AHA worked closely with the Department of Public Health and frequently made representations to the government, attempting to secure adequate sources of revenue for member institutions. The chief source of financial difficulty for the hospitals was the inability of many patients to pay for their inpatient care. Although various health insurance schemes were available to the public, they fell short of covering the full cost of hospitalization. The AHA achieved a major objective in 1948 when it sponsored a Blue Cross Plan for the pre-payment of hospital care. Ten years later, the association played an active role in the development of the Alberta Hospitalization Benefits Plan introduced by the provincial government (Ross, 1980).

As the financial support for hospitals became more predictable, the AHA was able to devote more attention to the development of membership services. Hospital boards were in a position to increase their contributions to the Association and consequently, more resources became available to provide education and consultation

services, and to promote accreditation standards.

The scope of activities of the Association increased in response to environmental forces and the rising expectations and demands of the membership. Traditionally, the goals and objectives have been set annually by the incoming Board of Directors for the forthcoming year. Needless to say, there has been a succession of subordinate goals and objectives over the years, but the broad general purposes have remained much the same. These may be summarized as follows: (a) The promotion of high quality hospital services; (b) The provision of member services including coordination of activities, education, and operational research; and (c) Representation of members in negotiations and discussions with government and other agencies.

The Board of Directors reiterated these general purposes in a recent resolution setting out the objects of the Association in a preamble to its bylaws. Two subsidiary objects are worthy of mention here. The first commits the AHA to "fostering and promoting the concept of local authority and control over the provision of hospital services" (AHA Bylaws, 1983, No. 2b). This object underscores the fact that, unlike other interest groups made up of individuals, the AHA is an interest group of independent organizations. The other object outlines the role of AHA in: "representing any or all members of the Association in collective bargaining with hospital employees, organizations representing hospital employees and trade unions, and regulating and promoting sound labour relations" (AHA Bylaws, 1983, No. 2e). There is an inherent incompatibility in these two goals in the case of province-wide collective bargaining, as the AHA has

limited means for requiring its members to join in a strong united front in the face of powerful opposition by unions.

The AHA established its labour relations program in the mid-1960s in response to the rapidly developing union movement in the hospital field. Collective bargaining became a key issue and although the largest hospitals were able to handle their own negotiations, smaller hospitals with a narrower range of resources were not, and those hospitals were willing to authorize the AHA to represent them in negotiations with employee groups. In order to satisfy the terms of the labour legislation for serving as a bargaining agent, it was necessary to seek an amendment to the Alberta Hospital Association Act of 1948. An amendment was passed in 1966 altering the objects of the Association, permitting it to serve as an employers' association for the purpose of collective bargaining.

Structural Developments

In a well-documented discussion of the developments in the complexity and formalization of internal operations of the AHA, Juzwishin (1980) observes that the changes were insignificant prior to 1959 compared with those that were to follow between 1959 and 1971. He attributes these later developments to the following factors:

- (a) increasing demands by the membership for more services, (b) the delegation of responsibility from the Department of Public Health to the association for education and consulting services, (c) the organization of hospital employees into trade unions and associations, (d) the acceptance of auxiliary hospitals and nursing homes to the association's membership, and (e) the funding of hospitals from provincial general revenues. (pp. 197-198)

In the first forty years of the Association's existence the work of the organization was accomplished through the efforts of individu-

als elected to the various offices, and by committees. Members of the Board of Directors and standing committees as well as the executive officers all served voluntarily. The Secretary was paid an honorarium for his services but otherwise there were no paid employees. In July, 1959, the AHA Board of Directors appointed its first paid staff member, Murray Ross (who later became the Association's first Executive Director), giving him the mandate to establish a permanent office and place the organization on a more efficient basis. An accountant, a nurse consultant, and clerical staff were soon added to the staff of the Association (Murray Ross, personal communication, October 17, 1983).

A formal organization evolved rapidly and the secretariat expanded to include consultants in education and special areas such as employee relations. The constitution and bylaws of the Association were amended from time to time, enlarging the Board of Directors, establishing an Executive Committee, and determining criteria for membership in the Association. Regional Conferences were set up so that member institutions in various geographic districts of the province could meet to discuss common issues and problems. A summary of the structure of the AHA showing both membership and secretariat is presented in Figure 1. This organizational chart was reproduced by Juzwishin (1980) from Association minutes of 1961.

By 1977, there were three classes of membership in the AHA, namely, active, associate (nursing homes), and special (extraprovincial health organizations). The Board of Directors consisted of 17 members, two of whom were ex-officio. The composition of the Board

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The page contained: Figure 1. Organizational chart of the Alberta Hospital Association, June 1961 from Juzwishin, D. (1980). A history of the Alberta Hospital Association: 1919-1971. Unpublished master's thesis, University of Alberta, p. 151.

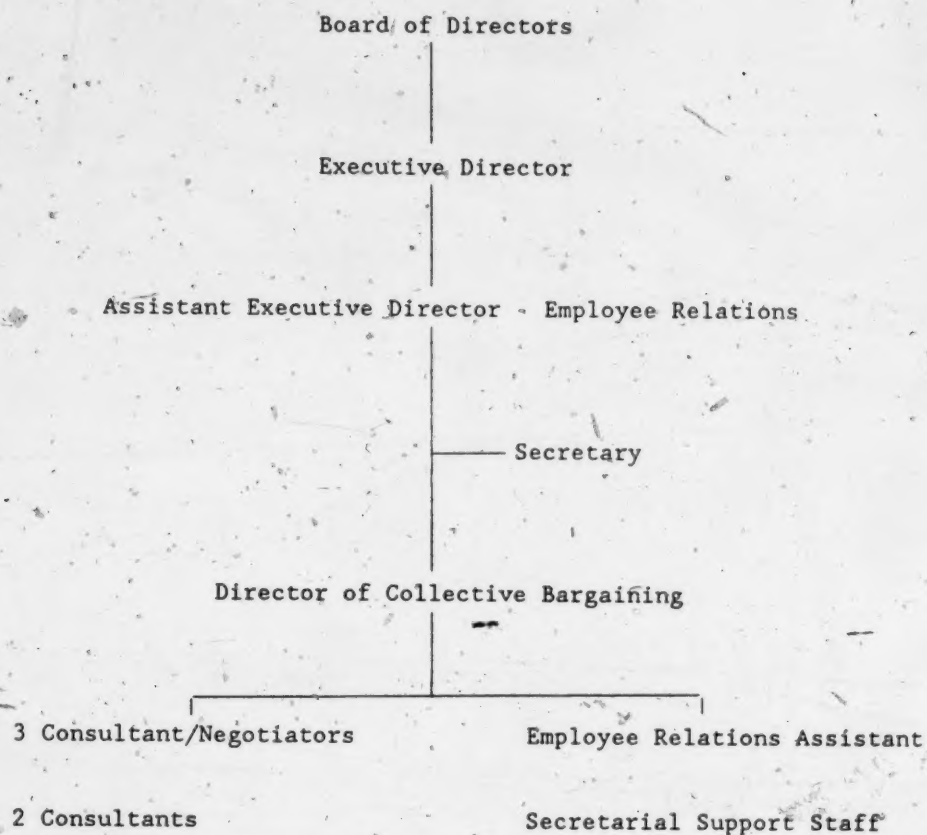
of Directors allows for five general members and ten representatives of the regional conferences, five of whom must be hospital trustees and five must be administrators. The term of the presidency is for one year and, traditionally, the incumbent is selected alternately from among trustees and administrators. The Employee Relations Committee is a standing committee of the Board of Directors comprised of thirteen members and chaired by a representative of the Board of Directors. Again, equal representation of trustees and administrators is the rule as well as representation from the small and large hospitals. These arrangements remained essentially the same throughout the period under investigation, with one exception.

The employee relations program became formalized under a Director of Collective Bargaining in 1977, and an additional senior administrative position was added to the secretariat in 1978. The incumbent Director of Collective Bargaining was promoted to the new position as Assistant Executive Director - Employee Relations and Consultation Services (E. L. Rheault, personal communication, December 4, 1983). An organizational chart of the Employee Relations Program of the AHA as it existed in the 1980 and 1982 strikes by nurses is illustrated in Figure 2.

Hospital Trustees

The people elected to serve in official positions of the Association are drawn both from the volunteers and paid staff of member institutions. Although hospital trustees comprise the dominant group within the Association, the mix of trustees and administrators is regarded as a strength of the organization both within the AHA and by

Figure 2. Organizational chart of the employee relations program,
Alberta Hospital Association, 1980-1982.



the Minister responsible for hospitals (Edward Knight, personal communication, September 21, 1983).

Hospital trustees being the dominant group in AHA, it is of some interest to mention the methods by which people become hospital board members. Trustees are selected by one of three methods to serve on district, provincial, or voluntary hospital boards:

1. Direct popular election, i.e., by election for the sole purpose of serving on a hospital board, in much the same way as municipal councillors and school board trustees.

2. Indirect popular election, i.e., by virtue of being elected to municipal or local council office and then being appointed to a hospital board.

3. Appointment, i.e., by the provincial government, a religious order, or municipal council (Radcliffe, Monsma, & Box, 1984). The typical district hospital board has five or six members, the majority of whom have been either directly or indirectly elected to the board. As Radcliffe et al. (1984) point out, such elected trustees are responsible to a specific electorate for hospital matters and serve the public through a mandate that is reviewed periodically.

The trustees of provincially owned hospitals represent the public at large on account of the fact that approximately 90 percent are appointed by the government for a specified term. On the other hand, voluntary hospital boards tend to acquire their members through a more diversified system of representation, but primarily by appointment. A recent survey of hospital trustees in Alberta revealed that the typical board member is male, between the age of 45 and 64; a

long term resident of the local community; a farmer or rancher; a high school graduate; and has served on a hospital board for less than four years. What is unique about hospital trusteeship in Alberta is that this is the only province in Canada where trustees can be popularly elected for the sole purpose of serving on a hospital board (Radcliffe et al., 1984, p. 24).

Employee Relations Program

The origin of the Employee Relations Committee dates back to 1959 when the AHA Board of Directors established a personnel committee to gather information on salary scales in neighbouring provinces and to suggest personnel policies and salary guidelines. At the time, the AHA had been issuing employee salary recommendations to its member institutions on an annual basis. In the case of nurses, the AHA issued salary guidelines after consultation with the Alberta Association of Registered Nurses. The two Associations were not always in agreement and sometimes they issued differing sets of recommendations to their members.

Trade unions by this time were actively organizing the general support workers in hospitals, and various professional and technical groups of employees were approaching hospital boards requesting voluntary recognition so that they might negotiate salaries and other terms and conditions of employment. Two major issues emerged, namely, the centralization of labour relations activities and the proliferation of bargaining units in the hospital field.

Centralization of negotiations. Generally speaking, most hospital boards lacked the financial and manpower resources to

undertake multiple concurrent negotiations with emerging collective bargaining units of employees. Moreover, it was acknowledged that if each hospital board negotiated independently with its employees there would be great potential for competition and whipsawing among bargaining units. The general level of interest and concern over the developments in the union movement was manifest in a high attendance of trustees and administrators at an institute on labour relations convened by the AHA in 1964. Thus, as Knight (1968) observed, it became clear that the AHA would have to provide a program of employment relations immediately.

An Employment Relations Officer was appointed in 1965 to develop a program of research, education, and consultation in support of the rapid developments in collective bargaining. By 1968, the AHA was engaged in collective bargaining on behalf of its members with ten separate professional and technical groups (Knight, 1968). For each employee group the AHA established a negotiating team and assigned a member of the Personnel Committee to each team. The teams were coordinated in such a way as to promote standardization in the terms and conditions of employment across employee groups. Thus, each team was kept informed of the issues facing other teams and the outcomes of bargaining. Group bargaining began late in 1965 when four Edmonton hospitals and their respective staff nurse associations joined forces for collective bargaining purposes, setting the stage for the subsequent province-wide model of contract negotiations (Van, 1967).

Employee organizations began to apply for certification as

bargaining units under the Alberta Labour Act for several reasons. The chief reason was that their employers would be obligated to recognize them and meet with them at the negotiating table. Secondly, they would be able to obtain the services of conciliation officers in the event of difficult negotiations, and finally, they would be able to resort legitimately to the threat of economic sanctions or to withdraw their services if necessary. The AHA had campaigned in the mid-1950s to have hospital employees excluded from the labour legislation in order to avoid strikes but, according to Juzwishin (1980), although the Department of Public Health was in agreement with the AHA, such an exemption did not materialize. However, it was not long after the third of the strikes reported in this study that the Progressive Conservative government removed the right of hospital employees to strike.

Rationalization of bargaining units. The problem of fragmentation of bargaining units in the Alberta hospital industry came to a head in 1972 with the appearance in the province of a new union, the Health Sciences Association of Alberta (Heise, 1975). This union sought to organize paramedical personnel some of whom had no interest in collective bargaining, while others were already members of rival unions. The determination of appropriate membership in collective bargaining units was a question for the public body responsible for administering the labour statutes, namely, the Board of Industrial Relations.

The AHA established a task force to examine the whole area of employee representation, job classifications, and optimal groupings

for the promotion of team work and effective patient care services. At that time, it had been estimated that there were approximately 150 distinct job classifications with more evolving daily. Moreover, there were seven bargaining agents vying with each other for the representation of hospital workers. In addition to these unions, many professional and technical occupational groups had been bargaining on a voluntary recognition basis either with individual hospital boards or with the AHA. As there was such a wide range of vested interests in the determination of appropriate bargaining units for the industry, this complex issue was not settled until 1977.

In its brief to the Board of Industrial Relations, the AHA recommended four broad groupings of employees based on the general community of interest of employees and their functional contribution to hospital services (Heise, 1975). However, in its Informational Bulletin No. 4 (1977), the Board of Industrial Relations set out guidelines for the hospital industry establishing five possible bargaining units, namely, employees engaged in:

1. Direct nursing care, encompassing registered, graduate, and psychiatric nurses, as well as nursing instructors.
2. Auxiliary nursing care, encompassing registered nursing assistants, nursing aides, orderlies, and plaster room attendants.
3. General support services, including clerical, food services, housekeeping staff, tradesmen and others.
4. Paramedical technical services, including medical records technicians, remedial gymnasts, radiological, respiratory and laboratory technicians, and others.

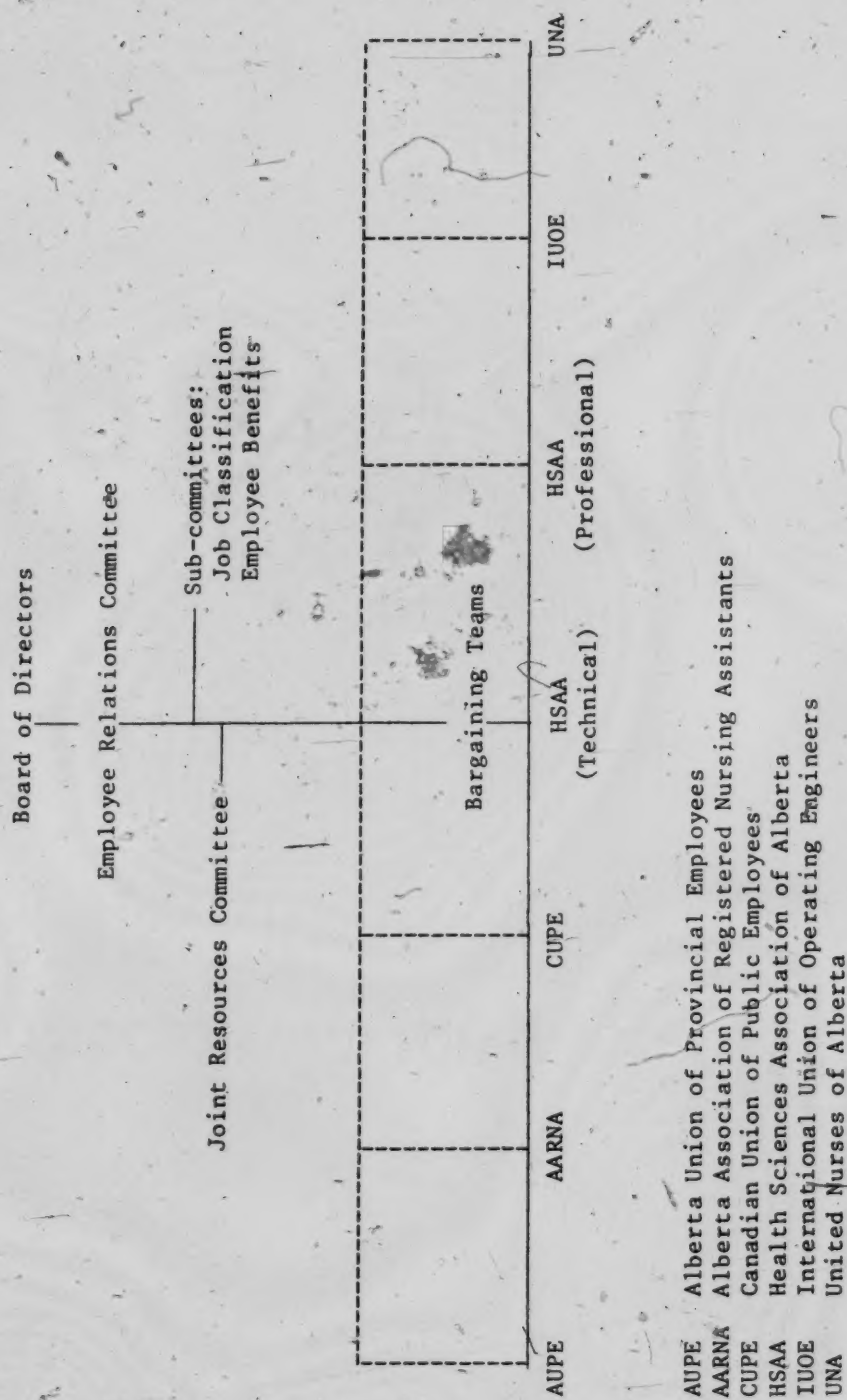
5. Paramedical professional services, eventually to include physical and occupational therapists, speech pathologists, audiologists, psychologists, and others.

These guidelines constituted far-sighted means for serving the hospital field under both private and public sector labour statutes. Although they limited the total number of possible bargaining units to five, no restrictions could be placed on the number of unions that might attempt to represent employees in hospitals.

During the latter part of the period under study, the AHA was negotiating on behalf of its members with six bargaining agents. The committee structure set up by the Employee Relations Committee is illustrated in Figure 3. This basic structure has remained remarkably stable throughout the history of the employee relations program provided by the AHA.

Assessment of the employee relations program. One of the objectives of the incoming AHA Board of Directors in January 1980 was to review its labour relations activities. Some members had expressed the view that other important activities of the Association were being adversely affected financially as a result of the employee relations program. Others were asking whether or not an independent and single-purpose employers' association should be established to handle employee relations such as existed in British Columbia. The AHA established an ad hoc committee to inquire into these matters and to assess: (a) the impact of the labour relations activities of the Association on the public's perception of the AHA; (b) the relations between government and the AHA; and (c) the labour relations prac-

Figure 3. Team structure for collective bargaining with hospital employee unions, Alberta Hospital Association, 1982.



tices of member institutions (Report of the Ad Hoc Committee, 1980).

The report of the Ad Hoc Committee was reassuring on the question of whether the other AHA programs were adversely affected by the expenditures on labour relations activities. An examination of the previous five years revealed that the proportion of the AHA expenditures incurred by employee relations activities remained comparatively stable over the period, for example, 32.6 percent of AHA expenditures were consumed by labour relations in 1980 compared with a high of 37.8 percent in 1977, and a low of 25.4 percent in 1979. The Ad Hoc Committee concluded that there was no real cause for alarm; however, it found that the number of secretariat staff engaged in labour relations activities was the lowest of five provinces investigated, and recommended a review of staffing requirements.

The Ad Hoc Committee also concluded that there was little to be gained by establishing a parallel organization to handle labour relations in the hospital industry. Other concerns of the membership were brought to light during the Committee's investigation, including attitudes, communication, and member solidarity during collective bargaining. As a result, the Ad Hoc Committee recommended that the AHA develop a statement of philosophy for employee relations consistent with good employee practices, and that it be made known to the members. Furthermore, it recommended that members wishing to participate in the bargaining process must be willing to accept such a philosophical statement (Report of the Ad Hoc Committee: 1980). The statement ultimately developed by the AHA appears in Appendix F.

Relations with Government

It has been a long established tradition of the AHA to pursue cooperative relationships with the provincial government. During the early years, it was to the mutual advantage of the AHA and the government to integrate their activities because both were interested in developing the hospital system, promoting acceptable operating standards, and generating sufficient funding for hospitals. Indeed, the spirit of cooperation between them reached an all time high between 1956 and 1958 when the provincial hospitalization benefits plan was being developed (Juzwishin, 1980). Once the hospitalization plan was in place, it soon became evident to hospital boards that while accepting a guaranteed source of revenue from public funds solved many operating problems, a certain amount of independence and autonomy would be lost in the process.

An amendment to the Municipal Taxation Act in 1973 removed the power of local hospital boards to requisition operating funds in the municipalities. Monies for site improvement could still be raised through local requisitioning, but the transition to a system of so-called last dollar funding was almost complete (Henderson, 1979). Although the government's decision to cover all hospital costs relieved hospital boards of the responsibility for fund raising, they were still entitled to generate revenues from such sources as parking fees and cafeteria sales. Hospital boards operated within a system of global budgeting, which is to say that once the total amount of provincial support had been determined for a particular hospital, a lump sum of money was allocated to the boards which could then be

administered however they saw fit. While this provided a certain amount of flexibility at the local level, it was generally conceded within the AHA that there had been a gradual erosion of the power and authority of hospital boards since the introduction of the hospitalization benefits plan (Henderson, 1979).

The operation of hospitals became increasingly complex and costly during the 1960s and 1970s. Health care costs soared as a combined result of public demand for health services, innovations in medical therapeutics and technology, the socioeconomic demands of employees, inflation, and sharp increases in fees paid to physicians. Hospital operating deficits became a fairly common phenomenon and operating surpluses were infrequently experienced. The hospitals division of the Department of Public Health, later to become the Hospital Services Commission, had been given wide powers in the administration of the hospitalization benefits plan including approval of the location and construction of hospitals; inspection and supervision of hospital services; and payment of insured services (Annual Report, 1958). These powers had the effect not only of a perceived reduction in the scope of financial decision making by hospital boards, but internal operations of the hospitals became susceptible to the scrutiny of officials in the administrative structure of government. Tensions developed between the AHA and government early in the 1960s when the Social Credit government of the day introduced annual fiscal guidelines, limiting hospitals to a predetermined percentage increase over the previous year's operating costs. Budget guidelines thereafter became an integral part of

hospital funding in the province. For example, a letter from the director of the budget division of the Alberta Hospital Services Commission contained the following instructions to hospital boards:

You will note that the enclosed 1977 budget forms provide you with a "target" figure for your net 1977 operating costs. This target amount of provincial operating support has been established in accordance with the economic restraints provided us for 1977 by the provincial government. Please complete your budget to the "target" amount. In cases where extenuating circumstances are such that the "target" support is believed inappropriate, the normal appeal procedures will apply. (Letter to all active treatment and auxiliary hospitals from D.L. Brandell, dated August 5, 1976.)

Appeal procedures were time consuming, and hospitals were often well into a fiscal year before the budget approval process was finalized.

The handling of operating surpluses or deficits by the government was a source of uncertainty for the AHA. The Minister of Hospitals and Medical Care, the Honorable Gordon Miniely, once declared in the Legislature that operating surpluses were the property of government while operating deficits were the responsibility of hospital boards (Alberta Hansard, 1978, p. 1147). Despite these declarations, the government usually "picked up" operating deficits (Murray Ross, personal communication, October 17, 1983), leading some administrators who were achieving balanced budgets to complain that the system of funding had few built-in incentives for running an efficient hospital.

Notwithstanding the tensions arising out of the level of provincial support for hospitals, the AHA has enjoyed extensive and influential relationships with both the political and bureaucratic levels of government. During the 1960s, the multiplicity of problems facing the hospitals led the AHA Board of Directors to make annual

presentations of briefs to the minister responsible for hospitals, and sometimes to the Executive Council, which included the premier of the province (Juzwishin, 1980). There have been many disagreements with the government over specific issues but, on balance, the views and proposals of the AHA are listened to and respected by the government, if not always adopted (Richard Baird, personal communication, February 10, 1984). Liaison committees and frequent interaction between the AHA secretariat and senior government officials have, with few exceptions, provided effective means of communication and exchange of information.

The system by which the composition of Alberta hospital boards is established ensures that the members are responsive to their local communities. Approximately one half of all trustees are local politicians, and because of Alberta's consensus voting patterns, trustees are likely to have affiliations with the ruling provincial party, and to be able to influence Members of the Legislative Assembly through their local political organizations in the constituencies. Given these circumstances, it has been difficult for the AHA to organize any serious opposition to government policy. It is the small rural hospitals that tend to be conservative, while the administrators and trustees of larger metropolitan hospitals are more likely to take a harder line on controversial issues and to be more critical of the AHA. This is particularly true when the problem facing the Association has to do with collective bargaining and hospital employees.

Government intervention in the 1977 nurses' strike was generally

opposed by the hard liners of the AHA for a number of reasons, one of which was because it represented yet another incursion into the authority, responsibility, and accountability vested in hospital boards under Section 27 of the Alberta Hospitals Act. Following the retirement of Murray Ross, the AHA Executive Director's position was filled by J. D. Henderson, a former Minister of Health in the Social Credit government and a somewhat feisty politician. Sometime later, Henderson circulated to all hospitals a discussion paper which he said was prompted by growing concerns over "the increasing emasculation of hospital board authority" (1979, p. 1). The paper seemed to be designed to galvanize the membership into a more aggressive stance vis-à-vis the government, but Henderson found little support for political activism, and he resigned from the Association not long afterwards (Murray Ross, personal communication, October 17, 1983).

In conclusion, the AHA has historically functioned as an interest group of independent hospital boards. Member institutions differed considerably on a number of dimensions including size, type, location, services offered, and recruitment to boards of trustees. The disparate interests of a diverse membership have resulted in tensions and divisions from time to time within the Association. Relationships with government have tended to be symbiotic, and where there have been differences of opinion on public policy, pressure on government by the AHA has been discreet. The AHA has avoided political activism throughout its history and has not openly criticized the government of the province. To have done so would have jeopardized the favourable relationship it enjoyed with both the political and

bureaucratic arms of government, and to have run the risk of offending many of its own constituents who themselves held close political ties with government (Richard Baird, personal communication, February 10, 1984).

Selected historical developments pertaining primarily to the labour relations services of the employers' association in the labour disputes under investigation have been described in this chapter. A corresponding overview of the origin and development of the nurses' professional association is presented in the following chapter.

CHAPTER VI

The Alberta Association of Registered Nurses

The nurses' union originated as a membership service of the Alberta Association of Registered Nurses (AARN). The purpose of this chapter is to describe the goals, structural developments, and employee relations program of the AARN up to the point at which nurses formed an independent trade union in 1977. The separation of the union from the parent organization occurred only two months before the first of three strikes that were the subject of this study. Much of the organizational culture of the union evolved during its early years as a collective bargaining division of the AARN, even though serious differences in ideology ultimately arose between the professional development and collective bargaining arms of the Association. An examination of the origin and development of the AARN, and of the internal dispute which culminated in the separation and establishment of the union, will serve to illuminate the events which followed shortly thereafter.

Origin of the AARN

The motivational force behind the initial organization of the AARN seems to have been a desire to gain control over the standards of practice in nursing, and in particular, to gain control over the standards of training programs for student nurses. The Alberta Association of Graduate Nurses (as it was originally titled) was launched in 1916 as a result of the combined efforts of four interest groups of nurses (Cashman, 1966). These groups had succeeded in obtaining legislation to allow them to register graduate nurses on a

province-wide basis. At that time, there were fears that this new society of nurses was in fact a union, and as Cashman observed:

The girls were certainly feeling militant, but they were getting things done at a faster rate than ever before. It was the age of Emily Murphy and Nellie McClung who led the fight to get the vote for the women of Alberta. The women of 1917 had abandoned the Victorian system of getting things done by having hysterics; giving men hysterics was more effective. (1966, p. 117)

Thus, the nursing association came into being three years before the Alberta Hospital Association, and was in a position to play a leading role in promoting the development of an association of hospitals in the province (Helen Sabin, personal communication, November 7, 1983).

The Goals of the AARN

The Registered Nurses Act of 1916 gave legal sanction to the two general aims of the AARN namely: "To promote the honour and status of the nursing profession, and to advance the standards of nursing education and nursing practice" (Helen Sabin, personal communication, November 7, 1983). The nursing leaders were clearly conversant with the political process, arranging to meet from time to time with the Premier and his Cabinet to discuss the concerns of the nursing profession. Moreover, they kept in close contact with the Alberta Hospital Association (AHA) and for years, held their annual convention jointly with the AHA (Murray Ross, personal communication, October 17, 1983).

The conditions under which nursing students were trained in Alberta became targets for change, and the socioeconomic status of private duty nurses appears to have been high on the agenda of many of the early meetings of the AARN. The minutes of the 9th Annual Meeting held in 1925 record the adoption of a 12-hour period of duty

(down from 24 hours), and a uniform "tariff" for private duty members. These were the early years of the Depression -- a time marked by widespread unemployment for private duty nurses in North America (Cashman, 1966; Wagner, 1980; Melosh, 1982), due to the inability of patients to afford the services of nurses in their own homes.

In the mid-1930s, unemployment of what were then called trained nurses remained a serious concern of the AARN, giving rise to the drive for an 8-hour day. However, the first formal structure for dealing specifically with socioeconomic issues, other than through the AARN Executive Committee, seems to have been the Eight-Hour Day Committee established in 1941 (AARN Provincial Council Minutes, June 1941). The mandate of this committee was evidently much broader in scope than its title suggests, because it was charged with the responsibility for improving the working conditions of both students and graduate nurses.

One of the earliest records of bilateral talks with the AHA is dated November, 1935. In response to an invitation from the AHA to a round table conference to be held at the 1935 Annual Meeting, the AARN replied:

Since you have asked us to submit questions and it has been brought to our attention, would you be good enough to discuss ... Graduate nurses working in hospitals 12-16 hours seven days a week, for \$15.00 to \$25.00 a month. (AARN Provincial Council Minutes, November 1935)

The problem of salaries and working conditions of nurses consumed a great deal of the Association's resources over the years, but the promotion of the socioeconomic welfare of the membership was not listed as an official goal of the organization. Indeed, these

matters were dealt with rather apologetically, despite acute awareness of the need to improve salaries in the province. To illustrate this point, Beattie (1945) noted that Alberta nurses were "loath to attempt any investigation or criticism of conditions as they exist while hospitals are so heavily burdened with 'more work and less staff'" (p. 781). She went on to add that the time was now ripe to take action in improving the social security of nurses and that a joint AHA/AARN committee would work together on a range of issues with respect to hospital employed nurses.

Attitudes were to change substantially over the next few years. The Canadian Nurses Association approved in principle the use of collective bargaining by provincial nurses' associations in 1944, and the nurses in British Columbia were already organizing in earnest to counteract the activities of trade unions in recruiting registered nurses. By the 1960s, collective bargaining had become a major preoccupation of the AARN, but it had been advised that to become a bargaining agent on behalf of its members, it would have to obtain an amendment to the Registered Nurses' Act. That was a necessary condition of becoming a properly constituted bargaining agent under the Alberta Labour Act. A third general aim of the AARN was approved in 1961, namely, to promote sound employer-employee relations (Cashman, 1966), but it was not until 1966 that the Registered Nurses' Act of 1916 was amended to incorporate collective bargaining activities on behalf of the membership.

Like the AHA, the AARN adopted various subordinate goals and objectives from time to time, increasing its services to members and

responding to social and political issues of concern to nurses, and of interest to the public served by nurses.

Structural Developments

The business affairs of the AARN, like those of the AHA, were undertaken by elected officers on a voluntary basis during the first thirty years of its existence. Operating decisions were made by a small Executive Committee, and the work of the Association was often delegated to ad hoc committees comprised of volunteer members. The chairmanship of such committees was frequently assumed by associate members, retired from active practice with the time and money to travel to meetings and to perform the work. Members of such committees, for practical and logistical reasons, were often the friends of the chairman. A more democratic and representational system would have required financial resources beyond those accumulated by the Association. There were not enough funds, for example, to consider paying the expenses of nurses travelling into the city from rural areas to attend meetings.

Prior to 1947 the Association consisted of eight districts from which delegates were selected to attend the annual meeting. Policy was formulated once a year at these annual meetings and officers were elected by voting delegates who were permitted to vote by proxy if necessary. The problem of inadequate membership representation in the affairs of the Association led to a bylaw change in 1947 which gave rise to the establishment of chapters. Chapters were then formed in areas of the province where nurses worked, for example, where there were hospitals. Even so, there were large parts of the

province where no Association chapters existed, and where nurses remained with limited opportunity to influence the business affairs of the AARN (Helen Sabin, personal communication, November 7th, 1983). By 1947, 7000 nurses had been registered with the Association, although only 1,900 were active members. The membership fee was \$5.00 per annum, which gave the AARN sufficient financial stability to expand its office staff to include a professional nurse as its Executive Director (Cashman, 1966). It was to be another 12 years before the AHA appointed its first administrator.

There were no further structural changes until the retirement of the first Executive Director and the appointment in 1960 of her successor, Helen Sabin. At the time of her appointment, there was provision for two professional staff members, an Executive Director and a Registrar, and two years later, a third position was added to allow for the coordination of Association committees. At this time the active membership stood at 4,382 (Cashman, 1966).

Employment Patterns of the Membership

Structural developments in the AARN were influenced substantially by changes in the employment patterns of nurses. The shift from private practice into institutional settings which began during the Depression years, resulted ultimately in hospitals becoming the major employers of nurses. Changes in nursing education which sought to reduce the service requirements provided by student nurses contributed to a growing demand by hospitals for trained nurses. After the second World War, many new settings opened up for nurses to practice nursing, for example, in industry, health clinics, airlines, and in

foreign missions. Table 5 provides comparative figures for 1930 and 1960, revealing that in the thirty year period the number of registered nurses employed in hospitals increased by 34 percent, from 25 percent in 1930 to 59 percent in 1960 (Cashman, 1966).

The final years of World War II were accompanied by shortages of trained nurses--a situation that was exacerbated by the construction of new hospitals in the post-war era. While many registered nurses had moved into institutional settings, the workforce in hospitals was being augmented by a growing body of auxiliary nursing personnel. The first certified nursing aide program in Alberta was introduced in Calgary in 1945. The response of the AARN to shortages of nurses was to launch a program for the reactivation of married nurses and to promote refresher programs, but these efforts were not sufficient to alleviate a growing sense of frustration with conditions of work in hospitals.

Table 5

Comparison of Employment Settings of Alberta Nurses: 1930 and 1960

Employment Setting	1930 %	1960 %
Hospitals	25	59
Private Duty	60	9
Public Health	15	7
Other	-	25
TOTAL	100	100

Note: From Cashman, T. (1966). Heritage of service: The history of nursing in Alberta. Edmonton: Alberta Association of Registered

Many changes were taking place in the hospital field. Medical technology and specialization were altering the pace and delivery of nursing services, particularly in the large urban hospitals. Hospitals were becoming increasingly complex and bureaucratic in their internal operations, and the general duty nurse began to sense a loss in status and alienation from the decision-makers and the source of power and influence. Dobbie (1967), commenting on the effects of bureaucratization in Alberta hospitals observed: "The rules and orders imposed upon the nurses due to the hierarchical structure and division of labour can be so binding and detailed that they almost deny the use of common sense!" (p. 5). If nurses were sensing that they were run off their feet in a system that was becoming increasingly complex and impersonal, the nursing manpower figures were suggesting that shortages of nurses were indeed a reality. In 1965, for example, the ratio of practising nurses to population in Alberta was 1:228 compared with the national average of 1:188, and was the third lowest of all provinces. Alberta was also below the national average in graduating university prepared nurses for leadership positions (Parker, 1967).

Staff Nurse Associations

The migration of nurses into hospitals from general practice brought nurses together in sufficient concentrations to form interest groups within the work settings. In the largest hospitals, nurses established staff nurse associations. As a matter of general policy, the AARN promoted these associations, not solely for the purpose of collective bargaining, but to encourage the members to assume respon-

sibility for dealing with their own employment problems and nursing practice issues. The AARN had no mandate to act in the case of a specific grievance, but it would attempt to influence an employer to rectify alleged injustices to students or graduate nurses (Helen Sabin, personal communication, November 7, 1983). Occasionally the AARN was invited to investigate problems brought to the attention of the Minister of Public Health, or to the AHA.

A staff nurse association was defined as an organization of active professional nurses employed by a health agency, exclusive of those involved in management or administration (AARN News Letter, 1965, p. 85). Staff nurse associations began to appear in hospitals in the early 1950s. At the Calgary General Hospital, for example, discontent among nurses came to a head in 1952 when there were mass resignations. A special meeting of the AARN Provincial Council was held to consider a long list of complaints brought by the staff nurse association representatives. A decade later the Calgary General Hospital was the site of renewed restiveness among nurses caused by a growing dissatisfaction with the system of personnel policy discussions which were, by then, being held annually between the AARN and the AHA.

The AARN kept itself well informed of collective bargaining events in British Columbia where nurses had been successfully organized by the professional association since 1946, and where salaries and working conditions were perceived to be consistently better than in Alberta. Alberta nurses' salaries had fallen substantially behind those in British Columbia by 1963, partly because of a three-year

agreement reached the previous year with the AHA. At the Annual Meeting of the AARN that year, discussion had been held with respect to the need for nurses to begin organizing within their employment agencies with a view to obtaining voluntary recognition from individual hospital boards. A resolution was passed that "when and wherever three or more nurses are employed, regardless of category, a staff association be formed and that recognition of such association by administration be sought and obtained" (AARN Annual Meeting Minutes, 1963). There was by no means unanimity on this issue within the AARN as the resolution passed with a slim majority of 85 votes to 79. Undoubtedly many of the opposing votes were those of the directors of nursing, whose role in relation to staff nurse associations was recognized as "being in need of clarification" (AARN Provincial Executive Minutes, November, 1962).

Experience with staff nurse associations among the hospitals varied, according to the minutes of a special meeting held in December, 1964 between the AARN and the AHA, as it was reported that at least two could not get past the hospital administrator to talk to the board of trustees. Shortly afterwards, the AARN created a new position of Employment Relations Officer for the prime purpose of promoting the formation of staff nurse associations, and to provide assistance in becoming certified as collective bargaining units under the Alberta Labour Act. M. Louise Tod filled the post, and by August, 1965, there were 25 staff nurse associations in existence. One year later, no less than 53 had been formed and 12 had obtained certification from the Board of Industrial Relations. Thirty eight

of the staff nurse associations had been voluntarily recognized by hospital boards. These developments were remarkable for the speed with which they occurred, spreading like contagion throughout the hospital industry with all the fervour of a social movement. The impact on hospital boards was dramatic according to Tod, who observed in her 1966 Annual Report: "The climate in which collective bargaining has taken place throughout the province has improved considerably and is approaching that of mutual respect, trust, and cooperation" (p. 2). Thus, the foundation had been laid for the structures which would eventually emerge as local chapters of the nurses' union, linked together for the purpose of province-wide collective bargaining.

The Employment Relations Program

The subject of collective bargaining was first placed on the agenda of an AARN Annual Meeting in 1944, the same year in which the federal government introduced its wartime labour relations regulations. It was also the same year in which the Canadian Nurses Association approved the use of collective bargaining by provincial nursing associations. Following the Annual Meeting, the AARN convened an Employment Relations Committee, giving it the mandate to study the socioeconomic status of nurses, and to make recommendations on salaries and working conditions. Upon the recommendation of this newly formed committee, the AARN approached the AHA requesting that a bilateral committee be established to address the serious concerns of nurses with respect to their social security. The AHA responded by placing a motion to this effect before the membership at its 1944

Annual Meeting, but the motion was defeated. Nevertheless, representatives of the two Associations met seven months later to discuss the question of whether to issue joint recommendations to their respective memberships on personnel policies for nurses. The issues raised by the AARN at that meeting included: minimum salary schedule with increments; hours of duty; vacation; sick leave with pay; hospitalization; and pensions (AARN Provincial Council Meeting Minutes, July, 1945).

While these developments were taking place, a large element of the Association's membership was either skeptical or openly opposed to the labour relations activities of the leaders. Few really understood the ramifications of collective bargaining and many did not wish to be aligned with unions if it meant taking part in militant activities such as picketing and striking. On the subject of strike, Esther Beith of the Canadian Nurses Association declared at the AARN Annual Meeting of 1946: "In affiliation with trade unions some union practices are not possible for nurses--'strike' is one word that should be unknown in the nursing profession" (AARN Annual Meeting Minutes, April 1946). Beith was reiterating the position taken by the Canadian Nurses Association that no nurse would withdraw her services at any time no matter what the circumstances, a position that was maintained until 1972, when the original resolution was rescinded under pressure from the provinces (Mussallem, 1977).

Beith noted in the same speech that there appeared to be three schools of thought at the time on what action nurses should take to improve their socioeconomic status:

The first holds for no association with trade unions, stating that the affiliation would lower the prestige and strength of the professional association; a second group advocates affiliation with trade unions for collective bargaining because it feels its professional association has failed nurses; and the third group feels that collective bargaining within the association or profession would be advisable. (AARN Annual Meeting Minutes, April 1946)

The Employment Relations Committee debated these positions at great length, consulting various sources of information: the AARN legal counsel; the chairman of the Board of Industrial Relations, Mr. K. A. Pugh (who was reported to be sympathetic to the plight of nurses); the Registered Nurses' Association of British Columbia; the Canadian Nurses Association; and the Alberta Teachers' Association, which had already gained considerable experience with collective bargaining. The Committee surveyed the membership with respect to personnel policies and practices of employers, and took on the task of disseminating information and educating nurses by issuing a series of labour relations "digests".

It became the practice of the elected officers of AARN to meet annually with the elected officers of AHA to discuss personnel policies for nurses and to issue a statement of recommendations to hospitals and nurses. Many hospitals adopted the policies but there were others that did not, giving rise to much deliberation within the AARN as to how pressure could be brought to bear on the hospitals that ignored the recommendations. The lack of uniformity in the implementation of the recommended personnel policies led to variation in terms and conditions of employment for nurses, especially between cities and small rural towns. For example, a survey of 112 hospitals in 1953 revealed that in 26 hospitals nurses were working 44 hours

per week, while in 23 they were working 48 hours per week. Moreover, 20 hospitals were still using split shifts, that is, had not yet implemented the three 8-hour shift schedule per 24-hours (AARN Annual Meeting Minutes, May 1953).

The Employment Relations Committee operated for twenty years or so as a group of volunteers advising the elected leaders of the AARN, until the first Employment Relations Officer was appointed in 1965. The Committee was ultimately replaced by the Provincial Staff Nurse Committee as an outcome of a change in the Association's bylaws in 1966. Meanwhile, the Registered Nurses' Association of British Columbia had been assisting nurses with collective bargaining since 1946, and had obtained recognition as a labour organization under the British Columbia Industrial Conciliation and Arbitration Act in 1947 (Goldstone, 1981). It was not until 1965 that the AARN became similarly involved in collective bargaining on behalf of its members.

The question as to why there was a gap of nineteen years between the adoption of collective bargaining by nurses under the pertinent labour statute in British Columbia and Alberta is an interesting one. The impetus for organizing nurses for the purpose of collective bargaining in British Columbia arose as a result of the activities of other trade unions operating in the health field. As Thompson (1982) suggests, nurses in British Columbia were obliged to act for defensive reasons to prevent nurses from joining other trade unions. In Alberta, there were no such pressures from the union movement in the health industry, largely due to a political climate that was less conducive to the development of trade unions than in the neighbouring

province to the West. Despite the early feminist achievements in the province of Alberta, there was little interest among women in unionization especially in the public service where many of them worked.

A fundamental problem in the development of collective bargaining by Alberta nurses can be identified in the organizational structure of the AARN. Apart from the Executive Director, Clara van Dusen, who was appointed in 1948, the Association was dependent on volunteers drawn from nurses in leadership positions to undertake the committee work needed to advance the goals of the organization. Representation of staff nurses in the affairs of the association was far from uniform across the province, as Association chapters had not been formed in all of the areas where nurses lived and worked. Moreover, the process of policy formulation was cumbersome, major decisions being made only once a year at AARN annual meetings. Attitudes to collective bargaining were mixed, but when pressure was exerted on the AARN by one or two of the larger staff nurse associations, its ability to respond to the members was limited by meagre human and financial resources. Services to the membership with respect to socioeconomic issues were not available until the cadre of paid professional staff was increased at the beginning of the 1960s. Also, there were legislative hurdles to overcome that required amendments to the Registered Nurses' Act if the AARN was to serve as a collective bargaining agent for its members.

Another factor in the development of collective bargaining by Alberta nurses was the nature of the bilateral discussions between the AARN and the AHA. Elected officers of both Associations met

annually from 1944 onwards, apparently to the satisfaction of both parties, that is, until the early 1960s. The AHA was, for the most part, quite sympathetic to the position of nurses, as it kept a close watch on the levels of salary and fringe benefits paid to hospital employees in other provinces. The AARN and the AHA maintained what might be termed an amicable relationship, seldom disagreeing on the need to offer comparable compensation packages to attract nurses and other health care workers into the province. This collegial spirit might have persisted, as Murray Ross commented: "if people hadn't become greedy" (personal communication, October 17, 1983), or if, as Helen Sabin noted: "the AHA had done something to smarten up the hospital personnel departments" (personal communication, November 7, 1983).

The mood of nurses was changing, particularly at the Calgary General Hospital where there had been a history of dissent and dissatisfaction. The Staff Nurse Association at the Calgary General Hospital forged ahead by obtaining the services of Ken Barrass, a labour relations consultant, and making application for certification from the Board of Industrial Relations as a collective bargaining unit. The first collective agreement of hospital employed nurses was subsequently signed between them and the Calgary General Hospital Board in 1965.

The AARN subsequently retained Ken Barrass as a consultant in employment relations. He was a skilled negotiator and an expert in the administration of collective agreements and his services as a consultant were made available to the Employment Relations Officer,

M. Louise Tod, and later to Yvonne Chapman. Barrass played a significant role in the development of the collective bargaining program in the late 1960s, providing on-the-job training for the AARN staff as well as workshops on labour relations for the general staff nurse members. Many years later, he was to play a leading role in the third of the strikes reported in this study, not as a representative of nurses but as the negotiator for the Alberta Hospital Association.

Formalization of collective bargaining. An event which did much to stimulate the interest of nurses in collective bargaining occurred in 1961. In an effort to curb the upward spiral in hospitals' costs, the Social Credit government of the day announced that hospital funding would not exceed three percent of the previous year's costs (Juzwishin, 1980). This event led to a three year agreement between the AHA and the AARN on salaries, during which time Alberta nursing salaries fell below those in British Columbia and Saskatchewan. The base rate for a beginning nurse in 1962 was \$290 per month rising to \$300 per month in 1964 (AARN Preconvention Executive Meeting Minutes, May 1962). The only reason why the AARN had agreed to these salary rates was that the government had also promised to introduce a pension scheme for hospital workers. Nevertheless, the low salary level spurred on the AARN to obtain advice in the field of labour relations and collective bargaining.

Professor J. Perroni of the University of Alberta was retained, and he pointed out that there would have to be a reorganization of the committee structure of the AARN to permit staff nurses to deter-

mine their own personnel policies free of the influence of nurses in managerial positions. This view was shared by the Deputy Minister of Labour who had made similar recommendations to the AARN (Special AARN Executive Meeting Minutes, April 1965). The last few months of 1964 and the first few of 1965 were marked by intensive consultation and deliberation at the AARN as to the options open to it. One high level meeting was held with the Premier of the Province and his Cabinet including a Mrs. E. Wilson, Minister without Portfolio, who had become interested in the situation of nurses (AARN Meeting with Cabinet, January 8, 1965).

The outcome of all of these activities led to the securing of an amendment to the Registered Nurses' Act and a major revision of the Association's bylaws. Bylaw changes were needed not merely to accommodate developments in collective bargaining, but to address other representational problems alluded to earlier. The AARN organization had to be restructured in order to meet three major objectives: to speed up the process of change within the Association; to create feasible channels for communication; and to bring about better representation of the membership (Helen Sabin, personal communication, November 7, 1983).

Five provincial districts were delineated from which representatives would be elected to the Provincial Council, i.e., the policy making body of the Association. The number of representatives was to be proportionate to the size of district membership, and meetings of the Provincial Council would be held in an open forum four times per year, limited only by physical space of the meeting place. Of

significance to the Employment Relations Program under the new bylaws was the provision for a Provincial Staff Nurse Committee (PSNC) having representation from each of the five districts. Only members eligible for membership in a bargaining unit were permitted to serve on the PSNC and its mandate was to take charge of collective bargaining. The PSNC was empowered to determine its own policies and to negotiate collective agreements on behalf of staff nurse associations. Ostensibly, the PSNC would be free of any influence from members occupying managerial positions. An employment relations officer was assigned to the PSNC for the purpose of implementing its policies, negotiating collective agreements, and handling grievances.

Purification of the structure. The question of whether or not the professional nursing association is an appropriate body to serve as the bargaining agent for groups of nurses has been discussed in the nursing literature for some years (Cormick, 1967; Seidman, 1970; Dolan, 1980). Membership in professional nurses' associations includes the full range of hierarchical positions from staff nurses and supervisors to directors of nursing and deans of university faculties, giving industrial relations boards good reason to consider whether bargaining units are free of employer influence. The new structure of the AARN implemented in 1966 was designed to protect the collective bargaining program from any form of interference or control by nurses in managerial positions, and indeed, the changes served the Association well for the next seven years.

A significant event occurring in Saskatchewan in 1973 led to another review of the AARN bylaws and further structural changes.

The Supreme Court of Canada upheld a Saskatchewan Labour Relations Board decision to deny certification as a bargaining agent to an affiliating local of the Saskatchewan Registered Nurses' Association, on the grounds that the majority of the officers of the nurses' association were traditionally employed in management positions (Thompson, 1982). This decision had implications for the collective bargaining programs of nurses right across the country. Fearing similar difficulties with certification procedures, professional nurses' associations began to study ways and means of protecting their collective bargaining programs by establishing autonomous divisions within their corporate structures.

The AARN sought legal advice as to the implications of the Supreme Court of Canada decision for the collective bargaining program. Legal counsel advised that in his opinion, both the structure and function of the AARN Provincial Council could be interpreted as having direct influence on the collective bargaining process. The leaders of the AARN therefore moved swiftly to secure the collective bargaining program by instituting what was termed a "purification process." New bylaws were drawn up and approved to provide for the functional autonomy of the collective bargaining program insulating it further from the probability of interference by Provincial Council.

The powers assigned to the AARN in the Registered Nurses' Act with respect to collective bargaining were accordingly delegated to the PSNC in order to forestall any effort on the part of a trade union to challenge the legitimacy of the PSNC as a bargaining agent.

The organizational structure of the AARN is illustrated in Figure 4, demonstrating the distribution of responsibilities delegated to the Association under the provisions of three statutes of the Legislature. The day to day operations of the various divisions were not significantly altered by the 1974 revisions to the bylaws, although certain technicalities had to be observed.

Generally speaking, the membership now regarded the AARN as consisting of two divisions, the professional development and the collective bargaining divisions. Special arrangements had to be made with a trust company to collect and distribute revenues to the appropriate division, as each division now had to have separate accounting and budget systems. In order to ensure the continuation of collective agreements negotiated under the old structure, application had to be made to the Board of Industrial Relations for successor rights for all staff nurse associations, and subsequently, these became known as staff nurse divisions. Nurses holding elected office in the collective bargaining division were precluded from holding concurrent office on the Provincial Council. Finally, the new structure created the position of Director of Collective Bargaining, which was immediately filled by the Employment Relations Officer, Yvonne Chapman. These changes having been accomplished, it was understood that the PSNC now satisfied all the requirements of a bargaining agent as stipulated in the Alberta Labour Act. Nevertheless, the leaders of the AARN recognized that in the long run complete separation of its two divisions was a distinct possibility. The new structure remained in place until 1977, the beginning point

Figure 4. Roles, functions, and structure of the Alberta Association of Registered Nurses, April 1974.

Role	Public	Profession	Individual
Function	Nursing Education: Standards for entry to the profession	Registration, discipline and membership services	Collective bargaining
Statute	Universities Act	Registered Nurses' Act Section 12	Alberta Labour Act
Structure	Universities Coordinating Council	Section 3(2)(c) Provincial Council	Provincial Staff Nurse Committee
		Executive Director	Director of Collective Bargaining
	Nursing Education Committee	Professional Conduct and Registration Committees	Staff Nurse Divisions

Note. Based on a model in: AARN Newsletter, Supplement No. 2, 1974, n.p.

of the focal period under investigation.

The Emergence of Intraorganizational Conflict

Over the course of the next two years, from 1974-1976, the efficacy of the purification process was not seriously tested or questioned. The Provincial Staff Nurse Committee (PSNC) continued to set policy, administer its budget, hire staff, and to provide negotiating and grievance handling services. The Director of Collective Bargaining was accountable to the PSNC but maintained an informal reporting relationship with the Executive Director of the AARN (Yvonne Chapman, personal communication, September 29, 1983). In all other respects the professional development and the collective bargaining divisions of the AARN operated autonomously and without formal interaction. In 1975 the AARN-Provincial Council increased the Association's fees from \$50 to \$75 per annum without incident.

An event which was to mark an irreversible break with the past and an inevitable path towards organizational separation occurred in June of 1976. Yvonne Chapman resigned her position as Director of Collective Bargaining on being appointed to succeed the retiring Executive Director of the AARN, Helen Sabin (AARN Provincial Council Minutes, June 1976). Chapman recommended to the PSNC that her assistant, Bob Donahue, be appointed to succeed her as the administrator of the collective bargaining program. It was at this point that some of the unanticipated consequences of the 1974 bylaw changes arose, casting considerable doubt as to whether the purification process had gone far enough in promoting functional autonomy.

Director of collective bargaining position. The AARN bylaws as amended in 1974 stipulated that the Director of the Collective Bargaining program must be a registered nurse. The chief architect of the bylaw changes had been Chapman, who had brought to her position in the collective bargaining division a strong nursing and administrative background. She joined the AARN as an employment relations officer in 1970 and proceeded to build a reputation for herself as a competent and trustworthy negotiator. She was highly respected by colleagues and especially by her adversaries on the management side of the negotiating table (Murray Ross, Tom Grothen, Bob Owen, personal communications, October 17, 1983; August 26, 1983; August 30, 1983 respectively). Donahue was hired in late 1972 as an information officer, and later was appointed to the position of Assistant Employment Relations Officer. One of his first tasks was to organize a strike of public health nurses in Calgary. Donahue came to this job with no formal collective bargaining education but with several years of experience in public relations in the Civil Service Association of Alberta and on-the-job training at the AARN. In his own words, he served an apprenticeship in labour relations with Chapman at the AARN while taking extra-mural studies at the University of Alberta (Bob Donahue, personal communication, October 29, 1983). It was Chapman's opinion that Donahue was the right person to succeed her for several reasons: he had the necessary skills, knowledge, and experience; he was well liked by the membership; and he had been an exemplary employee of the collective bargaining division. However, he was not a nurse. Chapman had not

anticipated any difficulty in securing a bylaw change to permit a non-nurse to serve as director of the program (Yvonne Chapman, personal communication, September 29, 1983). At the time, it was generally agreed that what the collective bargaining program needed was someone with technical labour relations expertise to provide the specialized support to the members of the PSNC. The Provincial Staff Nurse Committee was composed exclusively of nurses, consequently control over policy formation and the pursuit of professional interests would remain in the hands of nurses (Michael Mearns, Gurty Chinell, Joan Charbonneau, Yvonne Chapman, personal communications, September 23, 1983; October 24, 1983; February 7, 1984; September 29, 1983 respectively). Thus, the PSNC appointed Donahue as Acting Director of the program pending the necessary bylaw change.

Funding the collective bargaining program. The determination of revenue requirements to fund the collective bargaining division of the AARN was the central issue in the internal dispute and ultimate split between the two divisions of the Association, thus it is discussed here in some detail. Historically, the collective bargaining program was financed out of general Association revenues. A budget for the collective bargaining program was prepared annually and prospectively, and the PSNC was responsible for administering the funds allocated to it within the total organization's fiscal planning arrangements. There is little evidence of any serious problems with respect to the financial support for the collective bargaining program in its early years. The 1974 purification process heightened membership awareness of the need to design totally separate account-

ing systems even though registration fees and union dues were collected together from members of staff nurse divisions. In 1975, the PSNC set the union dues at \$25 per capita, per annum, while Provincial Council set a professional association fee of \$75 per annum. An Association policy determined that for in-scope members, the combined union dues and registration fees would not exceed the full professional association fee of \$75 so that nurses in the collective bargaining program paid \$50 only per year for registration. In other words, nurses who were unionized contributed less to the professional development division of the AARN than their non-unionized and out-of-scope colleagues. There was tacit acceptance of such a funding formula as it was well understood that salaries and benefits for all nurses in the province would be favourably affected by the outcomes of collective bargaining.

Following his appointment as Acting Director of Collective Bargaining, Donahue lost no time in galvanizing the PSNC into long range planning for the collective bargaining program. In a letter to the President of AARN he outlined an ambitious five-year plan for the growth and expansion of collective bargaining. The proposal included improved services to the members, and increases in the paid staff to allow for specialization in grievance processing, negotiations, research, education, and public relations. He wrote:

The immediate and major implication identified by the Provincial Staff Nurse Committee [is] the need to re-examine the present method of financing the Collective Bargaining Program The Provincial Staff Nurse Committee is requesting that the members consider a method of collection of collective bargaining dues separate from the A.A.R.N. registration fees. The amount being suggested is one-half percent of gross basic salaries. On an average this amounts to \$5.24 per member per month and would

include local Staff Nurse Division dues of \$1.00 per member per month. The dues deduction would be made on a monthly basis by the employer under a provision already existing in most collective agreements. (Letter to Audrey Thompson dated January 21, 1977)

This union dues proposal represented an increase of approximately 150 percent, and was later overwhelmingly endorsed by 84 of the 86 staff nurse divisions at a first ever general meeting of local representatives on February 23, 1977 (Gurty Chinell, personal document entitled "Summary of Events," no date).

Changes in the funding formula contemplated in Donahue's letter evidently would require a bylaw change indicating all too clearly that the PSNC was restricted in its ability to implement new policy by the bylaws of the Association. The 1974 constitutional changes would seem to have failed to insulate the collective bargaining program sufficiently from the decision-making power of the Provincial Council, being the only body entitled to deal with bylaw changes.

At a more practical level, there was the problem of how union dues would be collected should the proposed formula be adopted. If, for example, collective bargaining dues were to be collected by payroll deduction on a monthly basis, what effect would this have on the professional fee payable by unionized nurses to the professional association? At the time, staff nurses involved in collective bargaining were contributing two-thirds of their total fees to the professional development division of the AARN, and they saw no reason for changing this arrangement. Accordingly, in addition to some 24 other bylaw changes (Letter from R. R. Donahue, dated November 23, 1977), the PSNC submitted the following proposal to the Executive

Director of the AARN:

Bylaw V.1.(2) Collective Bargaining Dues

(a) A fee to fund the Collective Bargaining Program of the A.A.R.N. shall be determined by the Provincial Staff Nurse Committee on a per capita monetary requirement of 1/2 percent of gross basic income for each member of the Staff Nurse Division.

(b) The collective bargaining dues shall be submitted directly to the Provincial Staff Nurse Committee on the first day of each month.

(c) The A.A.R.N. membership fee of each member of the Staff Nurse Division shall be reduced by 2/5 of the total membership fee. (AARN Provincial Council Minutes, March 1, 1977)

Provincial Council reflected on this request at some length because, although theoretically it had no authority to deny the changes proposed in Bylaw V.1. (2) (a) and (b), the setting of the AARN membership fee was the sole prerogative of Provincial Council legally, and was a matter of historical precedent. It therefore agreed to publish the proposal contained in Sections 2 (a) and 2 (b), but not Section 2 (c). The PSNC angrily charged Provincial Council with acting ultra vires and interfering with union business, and it began to institute legal proceedings to challenge the consistency of the AARN bylaws with the Registered Nurses' Act.

Confrontation and conflict. The procedure for amending the bylaws of the AARN (as contained in those bylaws) was lengthy and time consuming, involving the publication and circulation of proposals for change to the membership 60 days prior to the meeting at which Provincial Council would debate and vote on the issues. This procedure ran counter to the egalitarian philosophy of the PSNC, believing as it did that such things as bylaw amendments should not be left to the decision-making of an elite few, but should be voted

on by the total membership.

Upon examining the Registered Nurses' Act as part of its review of the relationship between the two divisions of the AARN, the PSNC concluded that the changes it sought could be accomplished at a general meeting of the Association if it could convince the Provincial Council to convene a general meeting. The Act read as follows:

8. (1) The Association in general meeting may pass bylaws not inconsistent with the provisions of this Act or of any Act or regulation, respecting . . .

(b) the time, place and conduct of the annual and other meetings of the Association . . .

(d) the maintenance of the Association and the fixing and collecting of annual and other fees payable by the members of the Association . . . (The Registered Nurses' Act, 1916, R.S.A., Ch. 35)

The unionized membership of the AARN now stood at approximately 50 percent of the total registered nurse population, and there seemed little doubt that the PSNC had the power and the support to effect substantial changes in the Association's affairs, if the decision-making mechanism could be invoked at a general meeting.

The desire of the PSNC to have a general meeting of the Association became what might be described as an obsession, used at every opportunity to goad the AARN into action thereby creating a climate of mistrust, confusion, and anxiety. It now appeared that the only way in which the PSNC could effect the changes it wanted and remain within the corporate structure of the AARN was to take its case to a general meeting of the Association. There had been no such meeting since 1966, according to Chinell, Chairman of the PSNC, and so the game plan was to introduce a motion from the floor of the Annual

Convention scheduled for early May, 1977, to declare the assembly a general meeting, followed immediately by a motion that would write the proposed funding formula into the bylaws. A letter to this effect was sent by Chinell to the President of AARN on March 16, 1977. This, as Donahue observed, constituted a "nice threat" (personal communication, October 29, 1983).

It had become clear to Donahue by this time that neither the AARN constitution nor the physical capacity of the office building could be adapted to allow for the changes he envisaged for the collective bargaining program. A strategy would have to be devised to provoke Provincial Council into allowing organizational separation without jeopardizing the status of the collective agreements. At this point, most of the collective agreements had expired, and although negotiations had commenced in January, 1977, they had ended in stalemate after the sixth meeting with the Alberta Hospital Association. Backed by the PSNC, he claimed that he launched a campaign of orchestrated harassment and confrontation to demonstrate the inherent weaknesses in the 1974 structural arrangements that had been designed to give the collective bargaining program functional autonomy (Bob Donahue, personal communication, October 29, 1983).

The first signal that mobilization for action was evolving came when Chinell went to the retiring Executive Director of the AARN requesting that Yvonne Chapman be relieved of any further responsibility for the collective bargaining program, even though she was not scheduled to assume her new position as Executive Director for another month (Bob Donahue, personal communication, October 29,

1983). Soon after, Donahue sent a letter to the Standards Section of the Alberta Hospital Services Commission alleging that a nursing home had violated the Alberta Nursing Home Act Regulations by hiring persons not eligible for registration with the AARN. His letter requested the Commission to: "undertake a comprehensive study of nursing staff qualifications in all health care institutions" (AARN Provincial Council Minutes, December, 1976). This matter was of central interest to the PSNC in view of the fact that, under existing organizational arrangements, non-registered nurses were excluded from the collective bargaining program. This development, however, produced the desired embarrassment and confusion on Provincial Council, because, if such an allegation could be substantiated, it was clearly a matter for the professional arm of AARN to investigate, not the collective bargaining arm.

The next "assault" was on the bylaws, in particular a demand to delete the bylaw requiring that the Director of Collective Bargaining be a nurse, and this was followed soon after by the five-year plan announcement. No matter how the AARN responded, the PSNC reacted with skepticism, challenging the legitimacy of all actions and decisions, and producing counter proposals. Provincial Council proposed, for instance, that a liaison committee be established so that there could be regular communications between the two divisions of the AARN. One meeting was held in February, 1977, but all subsequent meetings were cancelled by the PSNC, only to be resumed sporadically after the collective bargaining division had seceded from the AARN.

At a special Provincial Council meeting called for March 1, 1977, the issue of funding was debated. In the event that the PSNC funding formula for collective bargaining was acceptable to the membership, the question was, would unionized members continue to pay a lesser fee for registration? The outcome of Provincial Council's deliberations was that the professional association fee could be lowered from \$75.00 to \$60.00 per annum for all registrants. The Association had an accumulation of surplus funds and so it was in a position to go part way towards meeting the PSNC's demand for lower registration fees for unionized members. However, refusal of Provincial Council to publish the PSNC's proposed bylaw amendments in their entirety led to allegations of gross management interference. Chinell wrote to all AARN Staff Nurse Divisions as follows:

The question that now faces staff nurses, in our opinion, is this: "Do we want a collective bargaining structure which operates at the whim of Provincial Council, or do we want a collective bargaining structure free from domination subject only to the direction of the Provincial Staff Nurse Committee?" (PSNC Memorandum, March 16, 1977)

The PSNC decided to appoint Donahue as its Chief Executive Officer authorizing him to begin drawing up a constitution for an independent union called the Alberta Nurses' Association, later to be known as the United Nurses of Alberta. Intraorganizational relationships at the AARN deteriorated into a state of turmoil and tension, and these stresses and strains frequently spilled over into work settings around the province. Ironically, Gurtey Chinell, Chairman of the PSNC, worked as a head nurse in the same Red Deer Hospital as the President of the AARN, Audrey Thompson, who held the position

there of Director of Nursing.

It was becoming increasingly clear that the controversy between the two divisions had become a serious dilemma for the Association. The President summed up the problem in a nutshell: "Provincial Council must vote on amendments [to bylaws] which relate to collective bargaining but in so doing cannot interfere with collective bargaining policy" (AARN Special General Meeting, May 6, 1977). In light of the legal proceedings that were now pending with respect to the bylaws, and the general direction that the PSNC seemed to be taking, concerns were being raised among Provincial Council members as to the legal liability of the Association for the collective bargaining division. After considerable debate at a closed meeting of Provincial Council the following motion was carried unanimously:

WHEREAS the A.A.R.N. established the Collective Bargaining Program for nurses in the Province of Alberta by amendment of the Registered Nurses' Act in 1966, and

WHEREAS the A.A.R.N. is on record as believing in collective bargaining for nurses and has demonstrated this belief by supporting a Collective Bargaining Program, and

WHEREAS this program flourished within the A.A.R.N., and

WHEREAS amendment of the Bylaws in 1974 created an autonomous Collective Bargaining Program within the structure of the A.A.R.N. in accordance with the terms of the Alberta Labour Act, and

WHEREAS complete autonomy now seems desirable, and

WHEREAS such complete autonomy would not affect the membership of any member of the A.A.R.N. nor the services that the A.A.R.N. can and will continue to provide to all members,

THEREFORE BE IT RESOLVED THAT Provincial Council provide for the publication of Bylaw amendments that would establish the Collective Bargaining Program as independent of the A.A.R.N. and further that sufficient time be given for the orderly development of an independent body to assume the

collective bargaining function. (AARN Provincial Council Minutes, April 22, 1977)

This decision was communicated to the PSNC giving immediate rise to a storm of protest and further allegations that Provincial Council was again dominating the collective bargaining program. As there was no mention of the PSNC or the collective bargaining division in the motion, the PSNC argued that the AARN could not legally establish an "independent body" to serve as a nurses' bargaining agent, and so it continued its verbal assault on Provincial Council.

The final chapter of this continuing conflict unfolded on May 6, 1977 when the AARN acceded to the demand of the PSNC and called a general meeting of the Association. Following yet another dispute over the agenda for the general meeting, it was determined that an equal period of time would be given to the President of the AARN and to the Chairman of the PSNC to present their respective positions to the membership. The latter chose to speak from the floor of the assembly rather than from the platform alongside the representative of her employer. There was by this time, widespread concern and misunderstanding among nurses everywhere in the province on the issues, on recent events, and above all, on the implications of the splitting up of the two divisions of the Association.

Thirteen hundred nurses attended the general meeting in Calgary on May 6, 1977, and heard the President of the AARN summarize recent events and explain the position of Provincial Council. She reassured the assembly that it had not been the intention of Provincial Council to be involved in the formation of an independent collective bargaining body. Rather, there would be a transition period for the present

organization to become re-established, and in due course, Provincial Council would rid the bylaws of any reference to the collective bargaining program.

An altercation ensued as to the mechanism for effecting this final purification procedure, with the PSNC insisting on a total membership vote rather than through the usual decision-making body, the Provincial Council. Two attempts by the PSNC to make motions to this effect were ruled out of order, and finally, Chinell announced the decision of the PSNC to form an independent union, requesting support from the AARN so that existing collective agreements would not be placed in jeopardy. Adjournment was abruptly moved and seconded by PSNC members (AARN General Meeting Minutes, May 6, 1977).

On June 14, 1977, the collective bargaining division moved into new premises as the United Nurses of Alberta. Staff nurse divisions made applications for successor rights as Chartered Locals of the new union. Province-wide negotiations had reached the conciliation stage at that point, having been held in abeyance since January, 1977.

In conclusion, the AARN served as the spokesman for nurses on a broad range of issues including socioeconomic matters, committing substantial human and financial resources to the establishment of a collective bargaining program. Ironically, it was the leaders of the profession who saw the necessity for adopting the means of the labour movement but who were generally ineligible for union membership themselves. For 12 years, the AARN functioned as a bargaining agent for those of its members who were entitled to belong to collective bargaining units in hospitals and community health agencies. Al-

though Association leaders were aware that such representation did not fully satisfy the requirements of the labour statute of the day, constitutional changes were undertaken to protect the decision-making autonomy of the collective bargaining division, i.e., to insulate union activities from potential domination by nurses in management positions. The full extent of that autonomy remained essentially unchallenged until new union leaders sought to test the legality of the Association bylaws over the issue of the funding formula for collective bargaining activities. Following a period of intense intraorganizational conflict, it became clear to the two Association divisions that their fundamental differences were irreconcilable, and that complete separation was not only desirable for the future well-being of both but, under the circumstances, inevitable.

The respective goals, structure, and labour relations programs of the AHA and the AARN have been described, but little has been said so far about the outcomes of their periodic negotiations to renew the collective agreement. The development of the collective bargaining relationship is therefore the subject of the next chapter.

CHAPTER VII

The Collective Bargaining Relationship

The socioeconomic interests of the membership had always been a concern of the Alberta Association of Registered Nurses (AARN), but the earliest record of what might be described as collective bargaining seems to have been in 1944. In that year, the AARN approached the Alberta Hospital Association (AHA) as noted earlier, suggesting that there be joint discussions on salaries and conditions of work for nurses. Over a period of the next 38 years, the relationship between the parties followed a course quite typical of unions and management in the public sector generally. In this case, however, the union underwent what might be termed a constitutional metamorphosis during that period, the specific circumstances of which have been described in the previous chapter. In this chapter, the development of the collective bargaining relationship is discussed and three phases are identified, reflecting an underlying change in the attitudes of nurses towards the means available to them for securing acceptable compensation and working conditions. The chapter concludes with an overview of the outcomes of the periodic negotiations between the parties during the latter half of the collective bargaining relationship, namely from 1965 to 1985.

Collective bargaining in the Canadian public sector emerged around the mid-1960s, and Ponak (1982) notes that a prevalent form of collective bargaining prior to that time was an association-consultation model. In the absence of labour legislation to support collective bargaining activities in the federal and provincial jurisdic-

tions, associations of public employees used various consultation mechanisms in pursuing their socioeconomic interests. These associations were usually opposed to such things as strike action and the compulsory membership requirements favoured by unions. According to Ponak, changes in the legal environment, and disillusionment with consultation mechanisms led public employees to reassess their earlier antipathy towards union strategies, and a gradual transition to union models of collective bargaining took place. The experience of Alberta nurses would seem to have closely resembled this general pattern, however, three distinct periods can be identified in the development of their collective bargaining relationship with employers: association-consultation from approximately 1944 to 1965; association-collective bargaining from 1965 to 1976; and union-collective bargaining from 1977 onwards.

Association-Consultation: 1944-1965

Although the AHA and the AARN had consulted each other on a wide range of issues over the years, the discussions on socioeconomic issues got off to a poor start with the rejection by the AHA membership of the AARN's request to begin talks. The Canadian Nurses Association approved in principle the use of collective bargaining by provincial nurses' associations in 1944, and at the time there were many concerns within the profession with respect to employment conditions generally. Nurses were in short supply by the end of the Second World War and the introduction in 1945 of auxiliary nursing personnel provided only a partial solution to the nursing manpower situation.

Despite the defeat of a motion to commence bilateral discussions with the AARN, the elected and executive leaders of the AHA were willing to meet with nursing leaders and by 1945, annual consultations had been established between the respective executive committees of the two Associations. The matter of minimum salaries for nurses was reported to be of some urgency in 1945, and according to the AARN Provincial Council minutes of January 1945, the AARN had threatened to take its case to the Minister of Trade and Industry. This appears to be the first of many such threats by the nurses, of which the AHA would seem to have had little to fear. The two Associations began issuing recommendations with respect to salaries and personnel policies for nurses each year, and this custom continued for the next 20 years. The parties were not always in agreement and sometimes two differing sets of recommendations were issued.

During this period of association-consultation, there were three serious disagreements between the parties. The first was in 1957 when, in anticipation of budgetary controls pursuant to the introduction of hospital insurance, the AARN recommended a substantial increase in salaries for nurses. The recommendation was unanimously rejected by the AHA (Special AARN Provincial Executive Minutes, August 1957). The second major disagreement occurred in 1962 and was again over the question of salaries, but at this point the government had become an additional actor in the process. In consultation with the AHA, the government unilaterally set \$290 per month as the starting rate for registered nurses, but what seemed worse was that it also set the salary rates for the two following years as well.

The starting rate of \$290 was \$10 short of the AARN's goal, but as noted in the previous chapter, the government had announced plans to introduce a pension scheme for hospital employees worth an additional economic benefit of five percent. Therefore, the AARN decided that it would not be expedient to protest further (AARN Provincial Executive Minutes, November, 1962). The rank and file nurses were clearly not as willing to acquiesce in this manner, especially the nurses at the Calgary General Hospital.

It was the Calgary General Hospital nurses who, together with their colleagues working for the Local Board of Health, reacted strongly to the fixing of salaries for a three-year term. They brought a resolution to the AARN's Annual Meeting of 1964 urging the Association to take the necessary step to become their bargaining agent under the terms of the Alberta Labour Act. The labour relations consultant retained by the AARN, Professor Joe Perroni, reported to the Association's Provincial Executive that nurses were convinced they were being paid less than they were worth. He noted that there seemed to be a benign neglect of their patient care concerns, and he pointed out that nurses had no grievance procedure. As he put it, "the hue and cry" was not for salaries alone, but also for raising professional standards (AARN Provincial Executive Minutes, April 1965).

A growing frustration and impatience with association-consultation can be detected in the minutes of AARN meetings. From the nurses' point of view, the employers were generally opposed to their suggestions for change, and what was worse, the AHA was perceived as

increasingly paternalistic towards the AARN. Helen Sabin recalled a 1963 meeting of executive officers of the AHA and the AARN in which the nurses were treated to a 45-minute "tirade of paternalistic hand-slapping." The AHA reminded the AARN that nurses had issued threats in the past but nothing had ever come of them. The full realization of the powerlessness of their position crystallized for the AARN leaders at that meeting (Helen Sabin, personal communication, November 1983).

The third dispute during this period of association-consultation arose in 1964 over the issues of salaries and premiums for head nurses who had obtained additional educational preparation. Salaries had apparently fallen behind those of nurses in British Columbia and Saskatchewan, and the parties were \$30 apart on that issue when talks broke down. There was also a serious disagreement on the educational demand that a premium be paid to head nurses for additional preparation. Negotiations however continued by mail, and in a letter to the AARN dated October 1, 1964, Murray Ross of the AHA concluded that the parties were not going to achieve a "meeting of minds." Consequently, the AHA unilaterally issued to member institutions, its annual salary and personnel policy recommendations. Whereupon the AARN released a second set of recommendations reflecting its own final position on the issues in dispute. It was the issuing of the two sets of recommendations that finally provoked nurses into searching for other means of strengthening their bargaining power.

Under the enlightened chairmanship of Madeline Quirk (a director of nursing), the Employment Relations Committee surveyed the staff

nurse associations, and met with nurses to determine their socio-economic needs and to discuss the two sets of personnel policy recommendations. Two general membership meetings were held in Edmonton and Calgary in October 1964 to discuss these matters, and nurses strongly urged their leaders to pursue collective bargaining with the AARN as their bargaining agent. The refusal of the Board of the Calgary General Hospital to recognize its staff nurse association on a voluntary basis led to the nurses' successful application for certification as a bargaining unit. The nurses at the Lethbridge Municipal Hospital and the Royal Alexandra Hospital in Edmonton followed suit shortly afterwards, thus ending a long period of what Crispo (1963) would call "collective begging."

Association-Collective Bargaining: 1965-1976

The collective bargaining relationship can be said to have matured during this second phase, that is, between the years 1965 and the end of 1976. Both the AARN and the AHA dedicated resources to the education of their respective members, informing them of the scope and limitations of a relationship that had now been drawn under the umbrella of the province's labour law and which was consequently more clearly defined. As the parties gained experience in negotiating and in the handling of grievances, their labour relations programs became more formalized and specialized.

Procedural Agreement

The dispute in 1964 over salaries and educational allowances for head nurses brought the question of the resolution of disagreements into much sharper focus. One point over which there was complete

agreement by the parties was that strikes and lockouts would not be used to settle disputes, and after lengthy discussions the AARN and the AHA signed a procedural agreement in December 1965. In effect, this procedural agreement substituted conciliation procedures for economic sanctions. This meant that whatever conclusions were reached as a result of negotiations (or conciliation as the case might be), the AHA and the AARN were bound to recommend acceptance of the outcomes to their respective principals. Ratification of such recommendations, however, would be the responsibility of the local hospital board and staff nurse association.

The procedural agreement seemed like a sensible and reasonable arrangement until 1970, when the AHA proposed an internship period for graduates of the new two-year diploma programs for registered nurses. It was suggested that for the first six months of employment, new graduates would earn 80 percent of the established basic rate of pay for registered nurses, the argument being that these nurses needed intensive orientation programs due to their lack of clinical skills. Predictably, the AARN was bitterly opposed to such a proposal, arguing that a return to an apprenticeship system would be a regressive step and that this was a professional issue of some magnitude. No agreement on the matter was reached and it was referred to a conciliation board for resolution. The conciliator ruled in favour of the nurses' position on the issue, but the incident demonstrated to the AARN that it could find itself in similar predicaments in the future. Had the conciliator's decision been otherwise, the AARN might have had to recommend acceptance of a

bargaining outcome to which it was fundamentally opposed. As a result, the staff nurse associations voted to abandon the procedural agreement in 1972, and in response, the AHA threatened to return to collective bargaining on an individual hospital basis. However, a new procedural agreement was reached two years later in which it was decided that the parties would be free to reject the outcomes of bargaining or conciliation, and be free to use whatever sanctions the legislation allowed.

The Question of Strike

The period of association-collective bargaining was remarkable for the ideological shift in the attitudes of nurses towards collective bargaining in general, and on the question of strike in particular. The AARN concurred with the Canadian Nurses Association policy rejecting the use of strikes by nurses, although it never issued an independent position statement of its own on the subject (Helen Sabin, personal communication, November 7, 1983). It was well understood that strike was available as one of the steps for resolving impasses, but it was generally assumed that no Minister of Labour would ever allow nurses to go on strike. The Association considered that the provisions in the Alberta Labour Act for declaring emergencies would probably be invoked if a strike were called (Louise Tod, personal communication, August 16, 1982).

Strikes in the public sector were becoming more common, and by 1966, some 3000 Quebec nurses had already taken part in a hospital industry work stoppage. In Alberta, a group of medical clinic nurses staged a brief and somewhat unsuccessful strike in Calgary in 1967

(Report of Employee Relations Officer to AARN Provincial Executive Committee, October, 1967). Six years later in 1973, Calgary public health nurses voted 87 to 3 in favour of strike action, and withdrew their services for seven days. In the same year there were threats of strike by nurses in two Edmonton hospitals that had broken ranks from the provincial bargaining group, now numbering 51 hospitals.

The strike issue at the Misericordia Hospital, Edmonton had been a two-tiered salary scale proposed by the Hospital Board to replace the six-step scale contained in the provincial collective agreement. At the Royal Alexandra Hospital, nurses had rejected a conciliation report primarily because the salary recommendations were not acceptable to them. Both these disputes were settled by negotiation at the eleventh hour, but there had been speculation at the time that nurses had voted to strike on the assurance that they would not have had to make good their threat. Casting an individual ballot in a strike vote is as much an expression of support for the negotiating team as it is a declaration of willingness to strike. Decisions are made usually on the basis of information supplied by leaders whose credibility at the bargaining table depends on membership support. Behind closed doors, strike plans were made in a state of stress and anxiety; no one wanted to strike, but as one Royal Alexandra Hospital union leader observed: "Everyone expected us as nurses to cave in at the last minute, but we were determined to show them that we wouldn't" (Joan Charbonneau, personal communication, February 1984).

The willingness of the hospital boards to concede to the demands of the nurses was no doubt influenced by the fact that both hospitals

had recently experienced strikes by hospital support workers with considerable disruption in services. Nurses were relieved that the strikes had been averted -- jubilant, in fact, because management was perceived to have backed down. This was a significant moment in the socialization of nurses in the tactics of unionism and not long afterwards, the AARN established an "emergency" fund (AARN Provincial Council Minutes, June 1973).

The Canadian Nurses Association had lifted its ban on strikes by nurses, and threatening to withdraw services had by this time become a respectable part of negotiating. Commenting on the threatened strike at the Royal Alexandra Hospital, the editor of the AARN News Letter wrote: "Throughout the entire proceedings their behaviour was beyond reproach" (1973, p. 2), noting that nurses had offered to provide home follow-up services to patients prematurely discharged from hospital on account of the strike. Attitudes among nurses were changing and they were losing their diffidence about the use of the strike weapon if necessary.

The period of association-collective bargaining began with the signing of the first collective agreement at the Calgary General Hospital in 1965, and ended with the separation of the collective bargaining division of the AARN in 1977. Groups of hospitals that had begun negotiating together in 1966 expanded their membership, and by 1976 had grown to a province-wide federation of 73 hospitals and their corresponding staff nurse divisions. Table 6 contains a record of all of the negotiations conducted by the parties between the years 1965 and 1984, a period which spanned the second phase of the collec-

Table 6

Record of Collective Agreements between Nurses and Employers: 1965-1985

Date	Number of hospitals	Term of agreement (years)	Method of settlement	Basic rate of pay per month \$	Salary increase %	Consumer Price Index change ^c %
1965	Individual	1	Negotiation	330 Jan.	4.6	2.4
1966	Group of 4	1	Conciliation Negotiation	355 Jan.	7.1	3.7
1967	Regional groups	2	Negotiation	380 Jan. 405 Jan. '68	6.6 6.2	3.6 4.0
1969	28	2	Conciliation Negotiation	440 Jan. 465 Sept. 490 May '70	8.0 5.4 5.2	4.6 3.3
1971	42	2.25	Conciliation Negotiation	520 Jan. 550 Jan. '72 ^a	5.8 5.5	2.9 4.8
1973	51	1.75	Conciliation Negotiation	605 April 625 Nov. 665 April '74 765 Nov. '74	9.1 3.2 6.1 13.1	7.5 10.9
1975	60	1	Negotiation	900 Jan.	15.0	10.8

(table continues)

Date	Number of hospitals	Term of agreement (years)	Method of settlement	Basic rate of pay per month \$	Salary increase %	Consumer Price Index change %
1976 ^b	73	1	Negotiation	972 Jan.	7.5	7.5
1977	69	1	Conciliation Strike Arbitration	1059 Jan.	9.0	8.0
1978	79	2	Negotiation	1123 Jan. 1217 Jan. '79	5.7 7.8	9.0 9.1
1980	86	2	Conciliation Strike Negotiation	1455 Jan. 1581 Oct. 1701 Mar. '81	16.4 8.0 7.1	10.1 12.5
1982	92	2	Disputes Inquiry Board Strike Arbitration	2041 Jan. 2225 Jan. '83	16.7 8.3	10.8 5.8
1984	92	2	Negotiation	2225 Jan. 2301 Jan. '85	0.0 3.4	4.4 4.0

^a Nurses vote to abandon procedural agreement between AARN and AHA. ^b Nurses decide to abide by

federal anti-inflation guidelines, but negotiate a wage reopener clause. ^c Statistics Canada,

Catalogue 62.001.

tive bargaining relationship and the beginning of the third.

During the eleven-year period 1965 to 1976 inclusive, the terms of the agreements negotiated ranged from one year to two years and three months, and in four of the eight rounds of bargaining, differences between the parties could not be settled without the help of conciliation services. Nevertheless, the AARN was successful in achieving significant improvements in terms and conditions of employment and, with the exception of 1976, the basic rate of pay for staff nurses increased annually in excess of the corresponding rate of change in the Consumer Price Index. The salary figure almost tripled in the eleven-year period, from \$330 per month in 1965 to \$972 in 1976. In 1976, nurses agreed to abide by the federal anti-inflation guidelines that were imposed late in 1975, which explains why the rate of increase for 1976 was no more than the Consumer Price Index for that same year.

Union-Collective Bargaining: 1977 Onwards

The establishment of the United Nurses of Alberta by the former collective bargaining division of the AARN marked the beginning of the third phase in the collective bargaining relationship. The new style of union leadership, described in the previous chapter, was a signal to the AHA that the relationship would change, and that there was potential for more confrontation and less cooperation than in the past. Within two months of declaring its independence of the AARN, the new union had called its first strike. The first six years of this union-collective bargaining phase of the relationship between the parties is the focal period of this study.

It will be seen in Table 6 that the number of hospital boards and union locals involved in the province-wide negotiations rose from 68 in 1977 to 92 in 1982. The terms of the agreements were two years in length with the exception of the 1977 contract which was for one year only. In the four rounds of negotiations in this period, two out of the four were settled by negotiation, two by interest arbitration, and in three cases there were strikes. The basic rate of pay for a beginning staff nurse more than doubled between 1977 and 1983. A detailed account of the three strikes can be found in Appendix A (1977), Appendix B (1980), and Appendix C (1982).

The two-year agreement negotiated in 1978 was the only contract in which the increases in rate of pay for nurses were less than the changes in Consumer Price Index. The AHA and the UNA had agreed to try "locked in" bargaining, and so the negotiating teams retreated to a mountain resort intending to conclude negotiations within one week; agreement was reached in 4.5 days. The negotiations came very shortly after a long and hard battle which the union had fought to receive the full amount of the arbitrated settlement of the 1977 dispute (See Appendix A). The memorandum of agreement signed in 1978 contained a seven percent increase in salaries for 1978, and a cost-of-living adjustment for 1979. No one knew at the time just what would happen when the anti-inflation guidelines were lifted at the end of 1978, and so this settlement was recognized as something of a gamble for the union. However, what was more important than salaries at that time in the union's development, was the promise of future stability and security as an organization. In return for

modest salary gains, the union settled for the Rand Formula (automatic payroll dues deduction) and the inclusion of casual employees in the bargaining units. These were important gains that would serve to strengthen the union, and to secure a continuous flow of revenue. Not every local was satisfied with this memorandum of agreement, and four bargaining units did not ratify it until it became clear that there was not much else they could do to improve it. The membership in general was not particularly happy with the settlement, but the union had exhausted its bargaining power and would not have been able to fight another battle so soon after the experiences of the previous year (Michael Mearns, personal communication, September 23, 1983).

Also in Table 6, it will be seen that in 1984 for the first time in the history of the collective bargaining relationship, the parties agreed not to raise the salaries of nurses. By this time, the right of hospital workers to strike had been abrogated pursuant to Bill 44, and the Alberta economy was experiencing a recession. The salaries agreed upon for 1984 and 1985 were approximately in line with other wage settlements in the province at that time.

In conclusion, the leaders of the AARN were responsible for taking the necessary initiatives to establish the collective bargaining relationship with the AHA, effectively developing the structures and procedures for handling a province-wide employment relations program for its eligible members. The second and third phases of the relationship, however, were ushered in on a groundswell of dissatisfaction by nurses at the grass roots level of the Association. Much of the frustration felt by nurses stemmed from a sense of powerless-

ness with the means available to them for pursuing their socio-economic goals. An amendment to the Registered Nurses' Act in 1966 permitted the AARN to represent its staff nurse members in collective bargaining. Although the AARN gave moral and material support to nurses eligible for inclusion in bargaining units, and served as a bargaining agent for 12 years, doubts remained as to whether or not these arrangements would have been upheld if ever challenged in the courts (Yvonne Chapman, personal communication, September 29, 1983).

An overview of the outcomes of contract renewal negotiations revealed that the parties required the assistance of third parties in a majority of cases, and that conflict resolution procedures became increasingly complex in the third, or union-collective bargaining phase of the relationship between the parties. Having presented the background picture of the collective bargaining relationship, attention is now turned to the specific circumstances of the strikes which occurred during the focal period of the study, namely 1977-1982.

CHAPTER VIII

Towards an Explanation of the Strikes

In the preceding chapters, the environmental context of the disputes under investigation was discussed and the origin and development of the two associations that comprised the principal protagonists were traced. This information together with the history of the collective bargaining relationship provides a background against which the circumstances of the strikes are presented and assessed. As stated earlier, the purpose of the study was to record the details of a series of legal strikes by nurses between the years 1977 and 1982, and to determine the causes of these disputes. Integral to this chapter is the chronological account of each of the three strikes, presented as Appendices A, B, and C. These chronologies contain details of the strikes compiled from documentary sources and verified by several of the strategic informants. Readers are asked to refer to these chronologies during the discussion which follows.

Throughout the process of theoretical sampling described in Chapter 3, it became clear that there was a preponderance of categories common to all three strikes. Several themes emerged as having persisted to a greater or lesser degree throughout the six years in which the strikes took place. For example, union ideology among nurses became manifest in the early part of 1977 and became a significant cohesive force within the union in its struggle for independence. It was much in evidence throughout the six-year period. Five themes were identified which provided a general framework for the

findings presented here, namely: union ideology; the worth of a nurse; redefining the employment relationship; negotiations; and political resources and constraints. The findings are presented within this framework and form the basis of the explanation as to causation in Chapter 9.

Union Ideology

The most pervasive theme identified in this investigation was the role played by ideology, especially union ideology. The term ideology is used here to refer to the system of beliefs and values adhered to by the leaders of the parties. It is important to note that the data collected do not pertain to the beliefs of particular nurses nor even of the median nurse, the median hospital trustee, or the median administrator. The method of inquiry was limited to information supplied by strategic informants, or gleaned from public and private documents. Almost all the strategic informants were people who played leading roles in the disputes and were either influential in, or engaged in, the decision-making processes whether within or between the parties. It must be remembered that the following discussion of beliefs and values pertains only to the beliefs and values as represented by these leading actors in the disputes. To say that the union espoused a militant ideology is not to say that all nurses or even all union members were militant unionists, but merely to say that the combined views of union spokesmen permitted such an interpretation. It was particularly clear, for example, that the rank and file nurses were seriously divided on the issue of registration during the third strike (Embury; Lamb;

Barrass).¹ Thus, it can be safely assumed that there was a range of attitudes among nurses towards union activities, but that nurses who chose to be involved as leaders were more likely to subscribe to union ideology as defined here.

The role of ideology is important because it is an integral component of the structure, substance, and process of collective bargaining. The nature of the demands and the extent to which the parties are willing to resist a proposal or set of proposals at the bargaining table, as well as the tactics and choices made in the give and take of negotiations are functions of the underlying ideology. The militant attitudes that union leaders demonstrated in the first strike were so unlike the attitudes expressed by them in previous years that representatives of the employers refused to believe that such attitudes truly represented the rank and file members (Mrazek). Mistrust of union leaders developed, and prevailed throughout the series of strikes. In order to understand the union's ideology, it is again necessary to turn to some historical antecedents to the 1977 strike.

The Mobilization of Nurses

The origin of protest behaviour can be traced to the early 1970s and the appointment of Bob Donahue as a staff member of the collective bargaining division of the Alberta Association of Registered Nurses (AARN). As a new employment relations officer in 1973, Donahue's job was to travel around the province promoting the develop-

¹ Strategic informants are cited in this chapter by last name only. An alphabetical list of strategic informants giving titles and dates of interviews can be found in Appendix E.

ment and effectiveness of local staff nurse divisions within hospitals. He became personally acquainted with nurses in all types of hospitals and he listened to them. He found that there were many problems in the work place but ~~that~~ nurses tended to be unwilling to deal with their circumstances.

Based on his observations, Donahue concluded that nurses were an oppressed group, controlled on the job by rationally and impersonally oriented managers, and controlled within their profession by leaders too far removed from the realities of the work place to represent them effectively. In his opinion, nurses were apathetic, lacking in any sense of personhood and self-esteem, and imbued with notions of altruism and servitude. He explained to the investigator that he could identify with the needs of such a group to free themselves from such invidious exploitation, because the plight of nurses was analogous to his own personal experience as a member of a minority group, the Metis. In his estimation, the human spirit had to be freed and consciousness raised in order for people to deal with their own situation and to take important, risky initiatives. Donahue said that he knew what he could do for such a group, and the prospect of galvanizing nurses into unionization suited his own needs at the time (Donahue).

As a frequent guest speaker at meetings of the staff nurse divisions of the Collective Bargaining Program at the AARN, Donahue embarked on a program of "radicalization", as he called it. Typically, his address would be organized around one of three general themes based on the writings of Douglas McGregor (1960), John Kenneth

Galbraith (1973), and Saul Alinsky (1971). McGregor's Theory X and Theory Y provided a framework for emphasizing the subordination of nurses to their employers; Galbraith's theory of the convenient social virtue provided an explanation for the historical exploitation of nurses as a female workforce; and Alinsky's Rules for Radicals suggested some operational tactics.

Donahue's program began with the premise that an employee is a person redefined by an organization in which he or she is employed. McGregor's (1960) Theory X, he explained, described the common and prevailing management style and attitude of employers towards employees. For example, Theory X suggested that in order to sustain productivity workers had to be directed, persuaded, rewarded, punished, and controlled by management. Employees were considered by management to be inherently lazy and motivated primarily by economic incentives, incapable of self-discipline, and essentially passive agents to be manipulated. Following a detailed analysis of the management rights clause in the collective agreement, Donahue would ask the nurses: "Does that ring any bells? Does that put into words some of your suspicions about your personhood in the eyes of the employer?" (R. R. Donahue, personal document, circa 1973). This was then followed by a description of hospitals in which managers subscribed to McGregor's (1960) Theory Y. Theory Y organizations, he explained, were characterized by decentralization of authority, participative management, opportunities for job enrichment, and mutual trust. In such organizations there was no inherent conflict between the achievement of individual and organizational goals. "Can

you determine to which of these two theories your employer subscribes?" Donahue would ask (R. R. Donahue, personal document, circa 1973). Thus, he urged nurses to examine the world as it was, in order to decide what they would like it to be, taking his cue from Alinsky (1971) who declared: "The basic requirement for the understanding of the politics of change is to recognize the world as it is" (p. 12).

A second theme of Donahue's speeches was based on the theory of the convenient social virtue advanced by Galbraith (1973). In Galbraith's own words:

The convenient social virtue ascribes merit to any pattern of behavior, however uncomfortable or unnatural for the individual involved, that serves the comfort or well-being of, or is otherwise advantageous for, the more powerful members of the community. The moral commendation of the community for convenient and therefore virtuous behavior then serves as a substitute for pecuniary compensation. (p. 30)

The concept of charitable services has been associated with nursing for generations, as have low wages and uncomfortable working conditions. A powerful argument could thus be made that, not only did a majority of nurses as married women contribute to the modern economy through the "administration of household consumption" (Galbraith, 1973), but that the convenient social virtue explained how low wages of nurses had served to subsidize the health care system. This argument formed the basis of Donahue's presentation to the Arbitration Board in 1977 (Brief of the Collective Bargaining Program of the A.A.R.N. 1977).

Donahue's indoctrination of nurses to unionization was continuous, low keyed, and persuasive. The rhetoric of memoranda, letters,

and position papers stressed the worth of a nurse's services; the rationality and impersonality of employers; the struggle for a fair distribution of income; the need for social justice; and the need for working conditions that would allow nurses to live and work with dignity. Rarely did Donahue appeal to nurses to take action on professional issues, but rather, he urged them to consider the power relationships between employees and employers. He argued that collective bargaining was the answer and the ethical means if "we want to be an effective countervailing force against the awesome economic power that the employer wields over us" (Donahue, 1976, p. 7).

There is little doubt that Donahue's attractive personality, his soft, well-modulated voice, impeccable manners and dress did much to strengthen the appeal of his arguments. His strategy was to encourage and invite nurses to say whatever they wanted to say about their employment circumstances, and to urge them if dissatisfied to do something about them: "You're going to have to arm yourselves with the courage of your convictions and come out of the shadows" (Donahue, 1976, p. 7).

Another reason for allowing freedom of expression was to begin the process of alienating staff nurses from the so-called elite decision-makers of the professional association. During the association-collective bargaining era, the processing of negotiating demands was limited to "serious and responsible" requests. Demands that were considered frivolous by the Director of Collective Bargaining were rejected and furthermore, demand-setting policy dictated that new

demands were to be supported by ten local staff nurse divisions before they could become part of the negotiating package (Chapman). An extraordinary commitment to a particular objective was therefore required to obtain representation because as one nurse said: "If you wanted to introduce an innovative demand, you had to go out and lobby nine other staff nurse divisions" (Ewart). Similar restraint was placed on the processing of grievances such that only those considered likely to be won were seriously pursued (Sabin). Under the radicalization program, nurses began to believe that their professional lives had been controlled not only in the work place, but also in their own professional association.

One objective outcome of the radicalization program was a huge increase in the volume and scope of demands brought to the 1977 negotiating table. The salary demands were unprecedented, and many new substantive issues were raised by the nurses. Moreover, they were accompanied by a "layman" as their leader and negotiator. These changes signalled a break with tradition, and nurses thereby served notice on the Alberta Hospital Association (AHA) that a new era of collective bargaining had begun. Massive negotiating demands became a union norm thereafter.

Confrontation Tactics

Another outcome of the radicalization program was the adoption of assertive and aggressive behaviour among union leaders. Donahue had successfully used confrontation tactics in his efforts to accelerate the separation of the union from the AARN. The conflict over

union dues at the AARN, for example, provided evidence that confrontation could be an effective tactic for dealing with individuals and agencies perceived to be authoritarian and manipulative. Having sown the seeds of discontent, Donahue was able to promote skepticism and mistrust of authority, or of any development which potentially threatened the rights of nurses to organize and to conduct their union affairs. Confrontation thus became an expected behaviour as well as a mind set for union leaders, but not for Donahue who said: "For me it was merely an intellectual exercise . . . I did not feel any antagonism towards the AARN" (Donahue).

Having seceded from the AARN in May of 1977, the nurses could turn their attention to the struggle developing in collective bargaining with the AHA. They had high expectations and were confident that they had a justifiable cause, and the apparent intransigence of the AHA during negotiations provided further evidence that an authoritarian body was again attempting to dictate what nurses could or could not do. This situation represented an intolerable obstacle to the achievement of their goals and a challenge that nurses were determined to overcome. Primed by the recent conflict with the AARN, the timing was right for a showdown with the employers' association.

Militancy

Confrontation at the negotiating table was one thing, but to take the membership out on strike required a great deal more conviction and courage. Aggressive behaviour displayed at the bargaining table did not develop overnight but had been gaining momentum since the end of 1976. Nevertheless, many nurses remained ignorant and

confused by the struggle that was taking place within the nursing profession. Others were worried about the speed with which events were taking place:

We would like to express our concern re the rapid movement towards a new collective bargaining unit for nurses in Alberta (UNA). The rapidity of action denies sufficient time for thoughtful consideration of the basic principles involved. (Letter signed by 189 "Concerned Nurses" to the President, University of Alberta Hospital Staff Nurse Division, June 16, 1977.)

Union leaders were feeling impatient and much less cautious, however, and unionism seemed to be spreading among them contagiously. Gurty Chinell recalled: "It was like getting the measles--you came to a meeting, you saw it, and you caught it" (Chinell).

At the Edmonton General Hospital, the executive officers of the Staff Nurse Division were called to account by a splinter group for their failure to keep the membership informed of developments within the union. Within days, the membership had secured the resignations of the entire executive and had elected a new slate of officers (Dancause).

Paradoxically, while nurses were celebrating their independence and growing sense of power as a unionized force, they remained malleable and responsive to direction. Most of them had very little knowledge about labour relations and the technicalities of collective bargaining, and were therefore dependent on the counsel of their leader. Donahue knew by this time that there would be an impasse in negotiations. He had personally generated the demands and heightened the expectations of the nurses, and if for no other reason, there had to be a strike to assure his survival as a leader. "Thank God they

could still be told what to do because I told them they had no choice and that they had to strike" (Donahue).

The fever of unionism ran high for the first two or three days of the strike, at which time Donahue directed 23 more local staff nurse divisions to serve strike notices. Later, he confessed that he seriously doubted his ability to sustain the strike because picket lines were beginning to falter. Even so, when the government intervened by declaring a public emergency, nurses in Edmonton expressed anger at the violation of their legal rights and threatened to disobey the government's Order-in-Council ("The nurses vote," 1977). Upon reflection, Donahue acknowledged that government intervention had come in the nick of time to "save his bacon". "It was a question of simple economics and I knew there would have to be a reckoning. We were broke and I wanted to save the nurses' money" (Donahue).

The strike served an important function for the union as a newly formed organization. It was a radicalizing experience for nurses, providing a first hand opportunity to learn about the power of the ultimate weapon of unions against employers. The strike brought the preceding months to a culmination as no other circumstance could, demonstrating to nurses just what could be achieved through concentrated effort and determination. It brought cohesion among the local staff nurse divisions and generated a commitment to the union's cause. One nurse described the prevailing sense of excitement as they set up their strike headquarters, and dug into their own pockets to rent a room and a telephone (Ewart). Another reflected on the growing militancy and solidarity among the rank and file members:

"We couldn't believe it--people came out of the woodwork in droves and voted 90 percent in favour of strike" (Dancause).

Rallying the members to the cause was an uphill battle during the first six months following the first strike. The Arbitrator in the dispute had denied the nurses their demands for a committee on nursing and a union security clause. The single symbol of success was the decision of the Arbitrator that he was entitled to exceed the federal anti-inflation guidelines, awarding them a three percent increase in excess of the six percent guideline. While this award was far less than the nurses had demanded, it was a significant concession under the circumstances. However, enthusiasm for the union waned as the struggle to secure the full award ensued, but time-consuming appeal mechanisms allowed the union to inform its members that governments and powerful individuals continued to deny nurses their rightful place in the social and occupational spectrum. During that time, Donahue made a film as part of his radicalization program, capturing scenes from the 1977 strike. Its concluding message was that to take up a picket sign was to join the labour movement.

Union Security

The United Nurses of Alberta (UNA) achieved financial security in January 1978, when the AHA agreed to a clause in the collective agreement authorizing automatic payroll check-off of union dues, or the Rand Formula as it was known. The union was now able to concentrate on its long term goals, including the consolidation of its power, the development of organizational stability, and the establish-

ment of an emergency fund.

The socialization of nurses to unionism continued under the influence of prominent unionist and feminist speakers, who were invited to give workshops on assertiveness and labour relations. Any reticence nurses may have previously felt about adopting union tactics and language was overcome because, as the first union President explained: "We grew more mature and we began to call a spade, a spade" (Chinell). Margaret Ethier, who succeeded Chinell, enunciated the reasons why nurses began to define themselves as workers:

When we realized we were being hoodwinked out of proper wages, bought off with the tag of being called "professionals," we decided to define ourselves as workers. After all, we were working pretty hard. We decided to form a trade union. (Ethier, 1984, p. 5)

Donahue was succeeded in 1979 by Simon Renouf, who clearly had no illusions about the nature of the nurses' union: "There is a big difference between us and other nurses' unions; there is no embarrassment about calling ourselves a union . . . the others are prepared to stoop to union tactics only when it suits them" (Renouf). Thus, the UNA made a conscious choice in becoming a trade union in every sense of the words, and in so doing could clearly distinguish and distance itself from the parent body, the AARN. Three months after his appointment as Chief Executive Officer, Renouf outlined what he felt the goals of the union were:

Some long-term goals are, I believe, fundamental to the role of our union: we should strive to organize all working nurses in Alberta, we should seek greater co-operation with our sisters and brothers in labour movements, and we should increase the level of awareness and activity of our membership. (Renouf, 1979, p. 2)

This was a clear indication that the new executive officer of the union would be continuing in the general direction already taken by his predecessor and elected union leaders.

Summary

The evidence and the discussion thus far suggest the following:

1. A change in the leadership of the Alberta Association of Registered Nurses marked the beginning of a period of conflict within the organization which culminated in the separation of the Collective Bargaining Division and the formation of an independent trade union for nurses.
2. Union ideology and militant attitudes of the membership were fostered by a new leader in a program of radicalization, using the techniques of social activists.
3. The propensity of nurses to favour strike action in 1977 can be attributed to the combined effects of union indoctrination, and the neglect of their grievances by employers and by elite colleagues in their professional association.
4. The experience of a strike served to demonstrate to nurses the power of unionism for achieving collective objectives, and contributed to the beginning of an identification with the labour movement.

The Worth of a Nurse

Nurses were no longer feeling constrained by the convenient social virtue and so it became the business of the union to determine the real worth of a nurse in economic terms. The first of this series of strikes occurred at a time when women generally were

appraising their changing role in society. 1975 had been declared by the United Nations, International Women's Year and many nurses were sympathetic towards the women's movement. Some were single parents and sole wage earners in families, and they had growing expectations that employers would at least respect their domestic obligations as female workers.

The union provided a forum for raising numerous questions about the value of nursing services. For example, what was it worth to an employer to secure the services of a skilled professional nurse to work on shifts, weekends, and statutory holidays; to be on call for emergencies; to work overtime if necessary; and to work anywhere he or she was assigned, even in ambulances? Such employment demands of a predominantly female workforce were considered atypical, if not unique, to nursing. Moreover, the work itself demanded a consistently changing knowledge base; technical skills; decision-making abilities, often of a critical nature; and professional responsibility for the quality of care given to patients. This was no ordinary job, yet the societal value placed on it in the form of compensation appeared to be no more than was placed on the compensation for semi-skilled work provided by such workers as building maintenance men, bakers, truck drivers, and forklift operators (Brief of the Collective Bargaining Program: 1977, p. 3).

Determining the worth of any position in a particular field is a complex task, but the short and simple answer from the union's point of view was that nurses were worth more. The worth of a nurse remained a persistent theme which simmered beneath all of the econo-

mic and substantive demands of the union in each of the disputes. The slogan "nurses are worth more" appeared on picket signs, in union communications, and was chanted on the steps of the Legislature: "We're worth more and we're not going back [to work]" (UNA, 1980, p. 1). Donahue explained to the Arbitration Board in 1977 that nurses felt an obligation to keep the services of the nursing profession highly valued, but "most of all they have acquired a sense of self-worth which precludes the use of paternalism or muscle by employers in the collective bargaining relationship" (Brief of the Collective Bargaining Program: 1977, p. 5).

A sense of relative deprivation thus prevailed with respect to wages during the first strike. Many of the nurses were married to workers in the oilfields and construction industry and so they were well aware of the kinds of salaries being offered to men whose qualifications they regarded as no better than their own, and in some cases, not as good. By the second strike, nurses were perplexed by the fact that the usual economic forces of supply and demand did not seem to apply to them. Hospitals were reporting an eight percent vacancy rate in approved full time positions for nurses (AHA Nursing Manpower, 1980, p. 11), a shortage which persisted until the middle of the 1982 dispute. The shortage of nurses, however, did not seem to be helping them to improve their salaries.

A shortage of nurses usually translates into increased workloads as employers strive to maintain the same level of hospital services to the public. It usually means more patients to care for per nurse, a greater likelihood of changes in shift schedules, and an increase

in demands for overtime work. It rarely means that the salaries of nurses go up.

The salary of a nurse had been regarded as a benchmark figure by the AHA over the years, primarily because of the size of the nursing workforce in the hospital system. As noted in Chapter 5, the AHA had tried to maintain salaries and benefits for all hospital employees in line with those paid in other provinces, seeing no reason for leading the field in these matters (Ross). Historically, the salaries of Alberta nurses had been slightly lower than those of British Columbia, roughly equal to those of Ontario, and somewhat ahead of those in Saskatchewan (Voight, 1976). Any unusual increase in the salary of a nurse would therefore upset not only internal wage relativities in Alberta, but also the long standing historical relationships with other provinces. This being the case, any major concession to nurses would undoubtedly have created a ripple effect throughout the hospital field, and fuelled the salary demands of several other unions. At the heart of these conflicts, therefore, was the union's determination to achieve a radical change in status for nurses within the occupational hierarchy of society, and the determination of the employers to preserve the status quo.

The First Strike

The underlying rationale for the union's demand for a salary increase of 36.8 percent was derived from a number of considerations. The most persuasive justification from the union's point of view was the recent compression in the differential between salaries of nurses and certified nurses aides (CNA). Seven CNAs had recently brought a

case of discrimination under the Alberta Rights Protection Act against the Royal Alexandra Hospital in Edmonton. The successful outcome of this case ultimately led to the equalization of the salaries of female aides and male orderlies, narrowing the differential between auxiliary nursing staff and Registered Nurses from 32 percent to 13 percent. The difficult question of what an appropriate differential should be had been submitted to an arbitrator in Ontario, who had settled on the figure of 25 percent ("The nurses vote," 1977). Alberta nurses were convinced that they had a special case, and that the AHA and the Anti-Inflation Board would surely recognize the validity of their demand for a generous increase in 1977 (Bennett).

In presenting their case to the Arbitrator, Donahue outlined the apparent inconsistencies between the salaries of nurses and several other professional groups, including physicians who were reported to be earning 400 percent more than nurses at the time. He wrote:

We are irresistibly drawn to the conclusion that logic has not been operating in the relative worth of the various hospital positions. The absence of logic at relative worth stage of salary administration would naturally lead to an irrational bargaining stance by the employer attempting to conserve the status quo. (Brief of the Collective Bargaining Program: 1977, p. 32)

The Arbitrator awarded a three percent salary increase in excess of the federal wage guidelines acknowledging the special case of nurses, but adding that their demand of 36.8 percent did "not commend itself to common sense in any way whatsoever" (Award of the Public Emergency Tribunal: 1977, pp. 9-10). In reflecting back on this award, the President of the union said somewhat bitterly: "We got very little

out of the 1977 strike" (Ethier).

The Second Strike

In between the first and second strikes there was one negotiated collective agreement. Donahue had clearly decided that union security and two years of relative labour peace at union headquarters were more important than another dispute over the worth of a nurse (Mearns; Donahue). The federal anti-inflation guidelines were still in effect, and so in the two year period that followed the 1977 strike, the salaries of nurses lost ground. The Consumer Price Index rose by 18 percent while salaries of nurses rose by 13.3 percent (See Table 6, pp. 147-148). By the time the 1980 negotiations began, the union was claiming that the average weekly wage of Albertans had risen 58.3 percent between January 1975 and June 1979, but that nurses' wages had increased by only 35.3 percent. Nurses would thus require a 23 percent salary increase in order to restore their purchasing power (Bunch, 1980). The initial demand of the union was for a 33.3 percent salary increase in a one-year contract. The provincial wage guidelines, however, were limited to increases of 7.5-9 percent for public sector employees.

The chronology of events in the 1980 strike (Appendix B) lists the series of attempts by third parties and the Minister of Labour to bring about an agreement between the parties. A 22 percent increase spread over a period of two years was recommended in the Conciliation Board's Report, but the nurses rejected the report in its entirety.

Resistance to the nurses' economic demands by the AHA and various third party actors in this dispute was firmly maintained

despite evidence of widespread public support for the union's position. Support for the argument that nurses were worth more came from various unexpected quarters. The medical staff of the Misericordia Hospital in Edmonton, for instance, passed a resolution: "Recognizing that we as Physicians, cannot function without a Nursing Staff, that is complete, competent, and content, do hereby and hereon, support them in their lawful contract negotiations..." (Minutes of the General Medical Staff Meeting, April 9, 1980). Even so, while individual physicians sported lapel buttons in favour of the nurses, the organized medical profession was urging the government to end the strike (Edmonton Journal, April 22, 1980).

Most of the editorial writers in provincial newspapers reported widespread public support for the nurses' position. The editor of the Edmonton Sun proclaimed: "In spite of the serious consequences of strike action, the nurses are justified in walking off their jobs" (April 16, 1980). In Medicine Hat, an editor noted that nurses were taking on more responsibility but that the rewards were not sufficient to retain them in the profession: "The plight of nurses is real and incontestable The price in this case is higher salaries, better working conditions, and more professional recognition for nurses. The government has no excuse for not paying that price now" (Medicine Hat News, March 29, 1980). The editor of the Calgary Herald agreed: "The nurses have a strong case to justify substantial increases in income levels which now do not properly reflect increases in the cost of living or the training and responsibilities involved in the profession" (April 9, 1980). And finally,

the editor of the Edmonton Journal had this to say: "Nurses enjoy wide public sympathy--probably as wide as the view that Alberta cannot do without its nurses" (April 22, 1980).

Support also came from the labour movement: "This year's nursing strike is catching the imagination of Albertans as a whole: it is energizing the labour movement as a whole" (Thorsell, 1980). The Alberta Federation of Labour donated \$10,000 to the nurses' strike fund, which constituted an unprecedented gesture to an unfiliated union, while the Alberta Teachers' Association urged its members to support the UNA by joining the nurses' picket lines.

It was becoming increasingly clear that the impasse would not be settled without a strike, and several hospital Boards of Trustees began to urge the AHA to be more generous towards the nurses. The AHA responded by making a last ditch offer before the strike, but many considered the offer to be unrealistic. For example, the Chairman of the Edmonton General Hospital Board wrote to the AHA:

We believe our credibility as responsible persons has been damaged as a result of the offer. Such an offer can only carry with it a feeling of rejection on the part of the nurses who are so essential to the entire health delivery system. (Letter to J. Henderson from G.L. Pickering, April 3, 1980)

The Board Chairman of the hospital in High River concurred with these sentiments, and in a letter to the Minister responsible for hospitals, urged the government to guarantee funding to hospitals so that a better offer could be made to the nurses (Letter from B.W. Johnson, dated April 11, 1980).

It seemed to the nurses that almost everyone, with the exception of the AHA, agreed that their services were "worth more". They

argued that nurses should at least be able to qualify for a National Housing Association mortgage, but this was not possible on 1979 salaries (Bunch, 1980). The union members stood firmly together on the issue of salaries, because they felt that it was not enough simply to gain parity with either British Columbia or Ontario nurses. Alberta was rich and its economy was booming; therefore, their salaries should equal those of other workers whose services were deemed to be of similar value to society.

The government ordered the nurses back to work after three days of their strike in 81 hospitals. After seven days of defying the government's order, the parties hammered out an agreement on salaries and other issues. They agreed to a 39.8 percent increase at the start rate of pay, staggered over a two-year contract.

The Third Strike

The union's salary demands during the third dispute were once again high. The Alberta economy was still strong when the nurses held their demand-setting meeting in the fall of 1981, but by the end of the year there were signs that it was slowing down. Initial salary demands were for increases of 40 to 52 percent in a one-year contract. According to the calculations of the AHA secretariat, the impact of the nurses' economic demands would amount to a 75 percent increase in the cost of hospital nursing services in the province. In addition, demands related to work schedules and shifts would necessitate expansion of the nursing workforce by some 635 full-time positions (AHA Press Release, October 21, 1980). Despite these initial salary demands, nurses claimed that money was not the major

issue in this round of negotiations; they wanted to make changes in the job itself and they wanted respect from employers. The president of the union summed up the rationale underlying the demands as follows: "We are valuable; we are in short supply; we have our own lives and personal needs; we want respect on the job; and we are worth what we are asking" (Ethier).

The strike was scheduled to start on January 1, 1982, but at the eleventh hour the Minister of Labour referred the dispute to the first ever Disputes Inquiry Board (DIB) under the provisions of the revised labour legislation. The chairman of the DIB recommended a 25 percent salary increase to be phased in over the first year of a two-year contract, and an increase in the second year equal to the Consumer Price Index for 1982. While this recommendation on salaries would have been acceptable to the nurses, they were infuriated by the "immoderate rhetoric" of the DIB chairman and his failure to deal with other non-economic demands. The report was variously described by the union as "a slap in the face," "evidence of lack of respect," "paternalistic," and an attempt to "buy the nurses off" (Ethier). According to the union's negotiator: "It would have permanently weakened the union to have accepted the DIB report, and so our future well-being demanded that we reject it" (Renouf).

The AHA was shocked by the financial implications of the DIB recommendations on salaries. Nevertheless, the Board of Directors decided to accept the report with "extreme reluctance" as a basis for a settlement and to avoid a strike. Any further negotiations would have to be within the ambit of the DIB report, but this was a prin-

ciple that the union was not about to accept. Further negotiations broke down and the union proceeded with its 23-day strike. Ultimately, a Public Arbitration Tribunal awarded a 29 percent salary increase over a period of two years, or roughly 5 percent less than nurses would have received had they accepted the DIB recommendations. The Tribunal, however, had acknowledged the importance of several other demands, for example, granting nurses the right not to be assigned to work alone on a nursing unit; not to have to work more than six consecutive shifts; no less than two consecutive days of rest at a time; two free weekends off in five; access to the Hospital Board in the event of unresolved problems arising from professional responsibility committees; and several other demands related to part-time and casual employees.

The preceding discussion has focussed on a single indicator of the economic worth of a nurse to her employer, namely her salary. Salaries represent only a partial measure of the total cost to the employer of the services of a nurse. As a general rule, there are very few provisions in a collective agreement that do not represent a cost to the employer. Benefits such as health care premiums, sick leave, vacation entitlements, and various other fringe benefits are estimated to be worth approximately one third of the total compensation package to employees (Heise). Collective agreements vary considerably in the total cost implications to employers--a factor which complicates the task of interprovincial comparisons during negotiations. Comparing the salaries of nurses in British Columbia and Alberta, for example, provides an incomplete measure of the

relative worth of a nurse's services. Suffice it to say at this point that, following the 1982 arbitrated award, the union negotiator reported to the membership: "Without doubt we now have the best collective agreement in Canada covering hospital nurses: the best working conditions and the highest wages" (Renouf, 1982).

Summary

One common feature of all three strikes was the magnitude of the union's salary demands. Although many other economic issues and demands were debated, negotiated, settled or abandoned during the bargaining sessions, salaries emerged as a key item in the disputes, contributing to impasses and subsequently, to strikes. In summary the following statements may be made:

1. The salary demands of the nurses' union exceeded the salary demands of other hospital employees' unions, and significantly exceeded existing federal and provincial wage guidelines in all three disputes.
2. The rationale for the union's salary demands in the first strike was primarily based on feelings of deprivation relative to: the salaries of other workers; an objective reduction in the salary differential between nurses and aides; a determination to correct perceptions of long-standing historical injustices; and a reassessment of the value of the services of nurses to employers.
3. The rationale for the union's salary demands in the second strike was based primarily on perceptions of: Alberta as the richest province in Canada and the social justice of sharing the

wealth; an objective loss in purchasing power; feelings of deprivation relative to the salaries of other workers; a sense of failure to correct historical injustices in the first strike and in the 1978 negotiated settlement; a strong belief that the services of nurses were undervalued; and a conviction that improved salaries for nurses would help to ameliorate the existing shortage of nurses.

4. The rationale for the union's salary demands in the third strike was based primarily on the belief that nurses were worth what they were asking, and that there needed to be a radical change in the relative standing of nurses in the occupational hierarchy of society. The salary expectations of nurses would have been satisfied by the recommendations of the Disputes Inquiry Board, had they not been linked to important substantive demands rejected by the Board.
5. Resistance to the salary demands of the union by the employers' association was based primarily on: fiscal constraints imposed by federal and provincial governments respectively during all three disputes; perceptions of the place of a nurse's salary as a benchmark figure within the health care system; and reluctance to disturb voluntarily the historical relationships with respect to interprovincial salary scales for nurses.
6. All three strikes occurred towards the end of a period of unprecedented economic expansion in the province of Alberta.

Redefining the Employment Relationship

A significant aspect of unionism is its potential for workers to achieve a measure of control in the workplace, and to exercise that control jointly with management (Karsh, 1958). To the extent that traditional common law rights to manage are yielded by the employer during collective bargaining, the employment relationship changes due to an alteration in the balance of power in the workplace. Unlike all of the other employee unions locked into a collective bargaining relationship with the AHA, the UNA tended to make numerous demands that would potentially increase the control and influence of employees in the workplace. During the course of the three strikes, there were many such demands over which there seemed to be no meeting of minds, due to some fundamental differences in the conceptualization of the role of the nurse in the hospital system.

A common feature of the more complex of these demands was the apparent intention of the union to redefine the employment relationship based on the theme of the responsibility of nurses to patients. The union sought to increase the scope of situations in which a nurse could reasonably refuse to respond to the directives of employers with impunity, for example, to work in an unfamiliar nursing unit, or to work alone on a nursing unit. A few of these issues have been selected for discussion here, based on their potential for throwing some light on the reasons why agreement could not be reached at the bargaining table, and to reveal the influence that union ideology had on the attitudes of union leaders towards the employment relationship.

Professional Responsibility Committees

Nurses' demands with respect to professional responsibility committees (PRC) were at the hub of the conflict in all three disputes, and they were considered to be strike issues by both union and management. The demand for a committee on nursing (later to be known as the PRC) first appeared in 1977, and its purpose was:

To study any problems relative to nursing care, any question which the parties may agree to discuss, any complaints of Nurses relative to their workload and to define the criteria and duties which permit a Nurse to receive the responsibility premiums provided for in the relief duties and responsibility allowance clauses. (Brief of the Collective Bargaining Program: 1977, p. 42)

This was not a unique demand as nurses in Ontario had already succeeded with a similar demand, albeit through interest arbitration (Gribben). Committees on nursing had been in existence in some Alberta hospitals since the early 1960s, but this concept was not something that employers wanted written into the collective agreement.

The position of the union on this issue was that committees on nursing were needed to deal with the concerns of nurses about their working conditions. Nurses said that they felt vulnerable and powerless to protect themselves in the event of errors made under the pressure of heavy workloads and understaffing (Bennett). They were also wondering where they would stand in the event of a tragedy caused by such things as medical incompetence or the mistakes of physicians (Gillis). One nurse said that it was much too intimidating to take complaints to management and so they wanted some means within the collective agreement whereby they could protect themselves

(Ewart).

To substantiate its position the union encouraged nurses to begin documenting the occasions when a nurse felt that patients were not being adequately cared for due to excessive workloads or other unsatisfactory circumstances. The notification form to be sent by the nurse to the employer was entitled "Disclaimer of Responsibility" and according to the union, by notifying an employer in this way, a nurse could be relieved of her professional responsibility (Brief of the Collective Bargaining Program: 1977).

Employers wanted nothing to do with "disclaimers" or with committees on nursing, and the item was one of 29 forwarded to an Arbitrator for resolution. At the Arbitration hearings, the AHA lawyer argued that to concede to such a demand would be tantamount to letting sailors run the ship--a statement that had infuriated the nurses (Mearns). The Arbitrator was evidently convinced, noting that to accede to the union's request would be to have allowed employers "to divest themselves of responsibilities with which they [were] charged" (Award of the Public Emergency Tribunal, 1977, p. 23).

The PRC demand reappeared in the 1979-1980 negotiations but was couched in much more dictatorial terms which the employers found totally unacceptable. A counter proposal of the AHA for an advisory union-management committee already provided for in other hospital employees' contracts was rejected by the UNA (Rheault). During conciliation hearings the union explained its stand saying that what nurses really wanted was the right to refuse work in circumstances which would prevent them from carrying out their responsibility to

patients. The question of whether or not a nurse could refuse (without attracting discipline) to undertake an assignment on the grounds that to do so would jeopardize the safety of patients already in her care, had recently been settled in favour of the employer in the celebrated Mount Sinai case (see Sklar, 1979).

On the question of the PRC demands, the Chairman of the Conciliation Board noted:

These proposals met extremely strong resistance from the Employer, to a point where it was almost impossible to engage the Employer in any discussion of the principles which might be inherent in these requests. In particular the Employer viewed the suggestion that nurses could refuse to work based on their individual interpretation of their professional responsibility to a patient as one designed solely to enrage the Employer. (Lucas, 1980, p. 22)

He went on to recommend that there be a PRC set up on a province-wide basis to take care of the professional concerns of nurses but not without rebuking the parties: the union for failing to produce evidence that patient care concerns were being ignored; and the AHA for "the undoubted lack of proper management techniques in some institutions" (Lucas, 1980, p. 24).

The union rejected the report of the Conciliation Board and the second strike took place shortly afterwards. The nurses were adamant this time, as indicated by one nurse who said: "It was no longer a question of what we would like to have in our contract but what we were going to get, and we were not going to return to work without the PRC" (Dancause). The PRC was one of the final items to be conceded in negotiations under the extreme pressure of a strike in 81 hospitals.

By the time the parties met for the next round of negotiations,

PRCs had been established in the hospitals. The union now argued that the committees merely provided a forum for discussion, not resolution, of patient care concerns and workload problems, and that there was a need to put more "teeth" into them (Chinell). One of the union's demands was therefore to provide for the referral of unresolved problems to an external assessment panel of expert nurses that would have similar powers to those of an arbitration board. Again, this demand was modelled on the experience of nurses in Ontario. In support of its position on this issue, the union proceeded to make a number of allegations designed to discredit management practices in Alberta hospitals and to expose what it considered to be some major problems in the health care system.

Allegations of management impropriety and inadequate or unsafe patient care were made by a number of union witnesses under questions from their legal counsel at the Arbitration Tribunal hearings following the third strike. The union's legal counsel, a prominent civil rights lawyer, claimed she could bring evidence of unresolved patient problems from most of the hospitals in the province (Arbitration Tribunal Proceedings, 1982, p. 2167). It was nurses, she argued, who had to deal with the consequences of an inefficient system. Such inefficiencies included: understaffing; outdated and unresponsive telephone systems; inadequate linen supplies; lack of proper in-service education; disrespect for patients at medical grand rounds; the questionable competency of casualty officers; the performance by nurses of non-nursing tasks, and many others. The attitude of witnesses summoned by the union was that their genuine desire to

bring about changes in the hospital system was being disregarded.

In addition to the testimony of nurses, the union drew substantially from the results of the AHA Nursing Manpower (1980) study in arguing for a stronger PRC. Although the union had counselled its members not to participate in the study (Moore), it pointed out that the findings supported many of its arguments about shortages of nurses and the dissatisfactions felt by nurses about their jobs. For example, in July 1980, there were 690 reported vacancies for registered nurses, 20 percent of which had been vacant for more than 30 days. Moreover, employers indicated that the vacancies would have been half as many again if they had budgeted on the basis of real need rather than according to budgetary guidelines (AHA Nursing Manpower, 1980, p. xvi).

The position of the AHA on the demand to extend the power of the PRC was unequivocal: Its lawyer argued that hospital boards had been granted statutory powers and duties under the Alberta Hospitals Act for the total operation of their institutions inclusive of the provision of nursing care to patients, and were accordingly held accountable. The AHA pointed out that these rights and duties were specifically recognized by the union in the management rights clause of the collective agreement. Moreover, external assessment panels raised a "myriad of legal and procedural questions" and thus it was categorically opposed to any mechanism having potential to oversee the statutory powers and obligations of a hospital board to manage its institution (AHA Submission to the Arbitration Tribunal, 1982, pp. 198-204).

Three of the 16 days of the Arbitration Tribunal hearings were spent on the issue of professional responsibility. The Arbitration Tribunal concluded that one of the major causes of the nurses' concerns was a lack of communication from management to the PRCs as to the disposition of the issues raised (Arbitration Tribunal Award, 1982, p. 117). Consequently, the demand for external assessment panels was denied, but a provision was made in the collective agreement granting the union the right to refer unsatisfied complaints (after three meetings of the PRC) directly to the hospital board.

The battle for the PRC exemplifies the conflict that arises when unions seek to increase their influence and control over the work itself, and when employers try to prevent the erosion of their common law right to direct the workforce, and to control the workplace. In this case, the union sought to broaden the scope of situations in which a union member might refuse the directives of a manager, to include the superior judgement of a nurse. The structure of nursing service organizations which ensures that the supervision of nurses is by managers who are themselves nurses, weakens the rationale for such a bargaining objective. An alternative strategy for achieving recognition of the superiority of professional judgement is to secure a forum in which discussions can take place on operational problems that impinge on the work itself. It can scarcely be denied that there might be some long-term benefits for all parties, including patients, to such an organizational structure. The means by which the union chose to pursue its PRC goals were largely responsible for the vigorous resistance it encountered. The many allegations of

improper management practices generated some bitter exchanges and represented "an invitation to the employers to dig in their heels" (Barrass).

Professional Issues

The theory of the expansion of bargaining suggests that once the traditional bargaining objectives of professional workers (salaries and fringe benefits) have been satisfied, the scope of bargaining will expand to include issues of importance to the profession (Klinggartner, 1973). It is not always clear just what represents a professional issue because, for example, in the third dispute nurses demanded that no nurse be required to work alone on a nursing unit. One might ask, was this demand motivated by a professional concern that in an emergency, a nurse could not be expected to resuscitate a patient and summon help simultaneously? Or did the demand represent a traditional concern of unions with the health and safety of its members? The union argued vigorously from both perspectives but the Arbitrator assigned the matter to Article 34 Health and Safety, which dealt with employee related issues (Provincial Agreement, 1982/1983).

Demands associated with continuing education have generally been regarded as professional bargaining objectives (Ponak, 1981), but such demands do not necessarily generate conflict at the bargaining table because they may be considered a simple cost item that is amenable to negotiation. A demand such as the PRC, however, represents what Goldenberg (1968) refers to as a normative demand. The aim of normative demands is generally to protect the role of the professional or to control the conditions and standards of profession-

al practice. It is these normative kinds of demands that are apt to generate the most resistance from employers because of inherent conflict between the rights of management and the "prerogatives" of professionals. In the third dispute there were several professional issues which contributed to the impasse in negotiations, but they do not seem to have been motivated by a desire to enhance the professional role of nurses, or even by any consideration of the public interest. These issues, if successful, would have had long range implications for the nursing profession and were strongly resisted by employers.

Non-nursing duties. The union claimed that there was deliberate understaffing of hospitals (Renouf, 1980b) and that nurses were being exploited, particularly in the smaller institutions. In seeking redress, the union negotiator explained to the Arbitration Tribunal that nurses needed to be able to prevent misutilization of their skills, and that at present they had no right to refuse to clean a refrigerator or to mow the hospital lawn (Arbitration Tribunal Proceedings, 1981, p. 2449). Hence, the union had included the following proposal in its demand package: "An employee shall not be required to perform non-nursing duties including: housekeeping, maintenance, laundry, kitchen, switchboard, pharmacy or medical duties" (UNA Negotiations Proposals: 1981, Article 36.12).

On the face of it, this proposal would seem to represent an attempt to protect the role of the professional nurse and to set some jurisdictional limits to the practice of nursing. However, by making this proposal, it was clearly intended by the union that disputes

over the question of what was, or what was not, a non-nursing duty would ultimately require some involvement of the arbitration process (Arbitration Tribunal Proceedings, 1982, p. 2452). Inasmuch as the nursing profession has engaged in a quest for a definition of nursing since the days of Florence Nightingale, had such a demand succeeded, the implications for the role of the nurse in Alberta were profound. Through the process of third party conflict resolution the union, apparently, would have been content to abide by the decisions of others in delimiting the activities of nurses on behalf of patients, and by association, in determining the nature of nursing practice. The Arbitration Tribunal commented on the impracticability of such a clause in the collective agreement and noted: "Insofar as non-nursing duties are concerned, until it is determined just what nursing duties are, such a Clause is not feasible" (Arbitration Tribunal Award, 1982, p. 119). It would seem that the objectives of the union in this case had more to do with the traditional union goal of establishing output standards than of any collective resolve to preserve and enrich the professional practice of nursing.

Registration. It will be recalled that during the 1977 period of conflict and confrontation within the Alberta Association of Registered Nurses (AARN), it was the issue of professional fees that fuelled the disagreements. One of the union's demands in the 1981-1982 negotiations threatened to revive old antagonisms between the AARN and the UNA and to draw the AARN into the collective bargaining dispute. The proposal was intended to eliminate the salary differential between Registered Nurses (RN) and Graduate Nurses (GN). A

graduate nurse was either not eligible for registration, or not yet registered pending the results of final qualifying examinations. In Table 7 the salaries for these two categories of nurses are listed for the years 1976 to 1983. It will be seen from this table that in 1976 there was a \$97 differential per month between the salaries of RNs and GNs at all steps in the scale, and that in the years 1978 to 1981, the salary for GNs consisted of a starting rate only.

At the time of these disputes, registration of nurses with the AARN was not a mandatory requirement under the Registered Nurses' Act (1916). Most employers, however, made registration and the maintenance of registration a condition of employment for nurses. The AARN and the AHA had agreed as far back as 1948 that this condition of employment was an important principle, and had instituted a two-tiered salary structure for RNs and GNs. Both Associations were firmly committed to the concept that in the absence of mandatory licensure, it was in the public interest to offer a financial incentive to nurses to maintain registration in the AARN. It was hoped that those ineligible for registration would be induced to upgrade their qualifications, but for the most part, employers assigned them to the same work as their registered colleagues. The AHA was determined to maintain the two-tiered salary structure, arguing that registration was an important means by which hospitals could assure the public that a nurse had met safe, acceptable levels of education and practice. Indeed, the issue was so important to the AHA that it had decided to take a strike rather than to concede to the union's demand (Barrass).

TABLE 7

Monthly Salaries of Registered Nurses and Graduate Nurses, 1976-1983

Date			Salary Scale					
			1	2	3	4	5	6
1976	Jan 1	RN	972	1010	1048	1085	1123	1161
		GN	875	913	950	988	1026	1064
1977	Jan 1	RN	1059	1101	1142	1183	1224	1265
		GN	954	995	1036	1077	1118	1160
1978	Jan 1	RN	1123	1167	1211	1254	1297	1341
		GN	1011					
1979	Jan 1	RN	1217	1265	1313	1359	1406	1454
		GN	1096					
1980	Jan 1	RN	1455	1508	1561	1612	1664	1717
		GN	1322					
	Oct 1	RN	1581	1639	1696	1752	1808	1867
		GN	1437					
1981	Mar 1	RN	1701	1759	1816	1872	1928	1987
		GN	1557					
1982	Jan 1	RN	2041	2112	2178	2247	2314	2385
		GN	1869	1918	1960	1994	2019	2036
1983	Jan 1	RN	2225	2303	2373	2449	2523	2599
		GN	2038	2090	2137	2173	2201	2220

The union argued from an egalitarian and individual rights perspective rather than from any commitment to licensure as a means of protecting the public interest. In essence, it argued that its own collective agreement contained a provision which permitted discrimination against approximately seven percent of its members, imposing on them a "penalty" amounting to \$1728 per annum at the start rate of pay, and \$5160 per annum at the maximum step of the 1981 salary scale. Since the law did not require mandatory licensure, the union wanted to remove any such condition from the collective agreement, not only because it was discriminatory but because some of its members no longer wanted to belong to their professional association. The continuation of the two-tiered salary structure, the union said, gave employers access to cheap labour (i.e., GNs) and constituted the sole mechanism for "propping up" the membership of the AARN. The union modified its stand at one point in the dispute saying that once a nurse had met the initial standards of the AARN, he or she should not have to maintain the qualification; in other words, some union members considered registration analagous to a driver's license, except that they did not want to renew it annually (Ethier).

The union's proposal created a singular dilemma for the AARN. Not only was the maintenance of its membership at stake, but if the union were to be successful with its demand, the AARN would be significantly limited in its ability to carry out its statutory obligations to the public, namely to maintain professional practice standards through the annual screening of practitioners and the

administration of discipline, should nurses choose not to renew their registration on a regular basis. A public relations campaign was launched by the AARN informing its members and the public of these developments at the negotiating table. Letters were sent to the AARN members (the majority of whom were also UNA members), advertisements were placed in newspapers, and a telegram was sent to the union urging it to drop its demand.

Union members were clearly split on this issue. The demand originated in only two union locals, one of which was the local to which the President of the union belonged (UNA Negotiations Proposals, 1981/1982). Letters from nurses in favour of the employers' position poured into the AHA (Barrass). In response to this three-way furore the union took the unprecedented step of placing the matter on the agenda of a special meeting, subjecting it to a decision of the voting delegates. As a result, the union's negotiating committee was given the overwhelming support of voting delegates to stand firm on the issue, but as one nurse said: "This really wasn't a big issue for us, but as soon as the AARN got into the act, it became one" (Dancause). Subsequently, the union launched a defamation suit against the AARN, prompted by the opinion that the public campaign of the AARN represented an unwarranted intrusion into the collective bargaining process--a suit which is still in process.

The Arbitration Tribunal spent a whole day listening to the arguments of representatives from the AARN, the UNA, and the AHA on the registration issue. In summarizing its position to the Arbitration Tribunal, the AHA representative said: "We serve the public of

Alberta and as employers we must do everything in our power that can be done to ensure that the nurses we employ are competent, and follow the basic ethics of their profession" (Arbitration Tribunal Proceedings, 1982, p. 1022). The Arbitration Tribunal ultimately ruled in favour of the employers but, in deference to the union's position, it restored a six-step salary scale for GNs.

In the case of this professional issue, the union had argued from a traditional union stance, reducing the debate to one of economics and the right of nurses to choose their affiliations. Curiously enough, the conflict over this issue cast the employers' association into the role of defender of professionalism, besieged by unionism.

Essential services. The issue of essential services arose not as a bargaining demand but as part of a continuing altercation during the third strike. The main source of the union's power in these disputes was its willingness to withdraw nursing services from all areas of the hospitals including critical care areas. The parties held diametrically opposed positions on the maintenance of essential services, the AHA expecting nurses to provide a minimum of services in critical care areas, and the UNA not wishing to debate the issue at all. Union leaders took the position that no worker is irreplaceable under certain circumstances, and rejected any suggestion that nurses should be legally or morally required to staff any area of a hospital when on strike (Renouf). This issue is discussed here because it serves to illustrate the union's interpretation of the duty of nurses to patients and to employers.

The parties were at semantic odds on this issue because the AHA

wanted to discuss essential services but the union would only discuss "emergency" services. The reason for the union's stance was that the first and second strikes had led to the declaration by the government of public emergencies, and the union contended that there had been insufficient evidence of such emergencies to warrant the suspension of the right to strike. Although there were allegations in the media that people had died as a result of both the second and third strikes, the evidence remained unsubstantiated. Following an unsuccessful court challenge of the validity of the Lieutenant Governor's Order-in-Council in 1980, the union vowed that the government would have to demonstrate the existence of a public emergency in 1982 or face a similar challenge (Renouf). Thus, the union's strike policies were designed to monitor the state of emergencies in the province.

The official position of the union on what was thought to be "essential services" was conveyed, if somewhat ambiguously, to the Minister of Labour during the third strike as follows:

Please be advised that the Locals of United Nurses of Alberta which are participating in strike action have affirmed that they will provide emergency services for the duration of the impending strike and have advised their employers of contact persons within each Local in the event of emergency In view of this arrangement, U.N.A. invites you to consult with us in the event that any circumstances giving rise to an emergency become apparent. We would then be able to respond to such circumstances in order to minimize the chance of an emergency developing. (Letter signed by Simon Renouf, dated February 5, 1982)

Representatives of the AHA, the government, and the Alberta College of Physicians and Surgeons were somewhat bemused and angered by the inferences contained in this letter. Medical staff in leading hospitals were of the opinion that it was a physician's prerogative to determine what constituted a medical emergency (le Riche). In an

emotionally charged meeting of all parties, to which the union was accompanied by its lawyers, an attempt was made to establish the meaning of Renouf's letter. In essence, the ~~UNA~~UNA's position was that the decision to offer emergency services would be made at the local level, but that nursing services would be available only under the following conditions:

1. If the local union strike committee determined that indeed an emergency situation existed; and
2. If no nurse, or nurse substitute with appropriate skills, could be found to provide the necessary nursing care; then
3. A nurse would go into the hospital to stabilize the situation and immediately withdraw; and finally,
4. No services of nurses would be provided which would assist the employer in maintaining any operations on a continuing basis.

Recognizing the potential for lack of cohesion among union members on the question of maintaining essential nursing services, it was politically expedient for the union to permit local autonomy on this matter. Some nurses would undoubtedly be torn between loyalty to patients and loyalty to striking peers. One group of nurses in Edmonton, for example, maintained services in a neonatal intensive care unit until the employer, fearing an ultimate walk-out, air lifted four babies and their parents to a hospital in Saskatchewan. The union charged the AHA with attempting to lay a "guilt trip" on the nurses (Chinell), and the union President remarked: "I told the nurses they were crazy to stay in the ICU because they'd never get out without being labelled 'baby killers' . . . nobody thanked them

for staying in" (Ethier).

The attitude of union informants towards the strike experience was unanimous--nurses did not like to go on strike. "Wages are lost and you never know if you will win or lose. You get abuse from the public on the picket lines, and you know there will be patients lying in shit for days" (Ethier). When questioned by media reporters about their feelings on abandoning patients, picketing nurses replied that the risks to patients were no more and no less than under normal circumstances when units were deliberately understaffed. They invited reporters to visit the hospitals when the strike was over so that they could be shown cases of neglect, pain, and suffering (Dancause; Chinell). Nevertheless, there were nurses who worried about what was going on in the hospitals, and they comforted themselves by saying that of course they would respond to save lives in the case of a real emergency or disaster (Dancause; Lorenz).

Once nurses had withdrawn their services they had no obligation to the employer and therefore no responsibility to patients, according to the union. What went on in a hospital during a strike was entirely the employer's responsibility. The union negotiator pointed out that in the 1982 strike, there were approximately 1000 management nurses in the province and as the AHA had had plenty of time to prepare for the strike, employers should have been "warming them up" to provide essential services (Renouf).

Employers' requests of the union to provide essential services during the 1982 strike were generally refused. The response of union locals was that essential services could be assured only if the

employers would agree to union negotiating demands. One local union president wrote to a hospital administrator:

It is in your power to contact the Alberta Hospitals [sic] Association and demand that a settlement be reached so that we can avoid having to withdraw services and interrupt in any way the excellent care provided by our nurses. (Letter signed by Sharon Lea, December 23, 1981)

Thus, the position of union leaders would seem to lead to the conclusion that the professional responsibility of a nurse to the public was viewed as one that was limited to the employment relationship. When not at work for whatever reason, a nurse had no obligation to provide services even of an essential nature. Responding to emergencies was a matter for the individual nurse to decide and would depend on circumstances as well as on evidence of the need for nursing services.

Duty of nurses to patients. Disagreements over the provision of essential services illuminates the concept of the duty of nurses to patients as articulated by union leaders. When at work a professional nurse has a primary and overriding responsibility to patients, the Arbitration Tribunal of 1982 was told, and "by fulfilling that responsibility, [the nurse] is fulfilling her obligation to the employer" (Arbitration Tribunal Proceedings, 1981, p. 2051). Accordingly, nurses have a duty to provide care to patients that is based on the standards set by the nursing profession. What constitutes acceptable care is determined by the nurse, and unless the employer provides the necessary resources and optimizes the circumstances under which the care is given, a nurse cannot honour her commitment satisfactorily to patients. Implied in this conceptualization is the

theme that the employer can and must control all contingencies in the workplace that impinge on a nurse's ability to give the necessary care to patients.

Paradoxically, the union expressed contempt for the efforts of some employers to introduce systems in the workplace that had received wide support within the nursing profession. For instance, in its brief to the Standing Committee on Public Affairs, the union noted that changes in corporate structures of hospitals had led to privatization accountability practices akin to the Taylorisms of the scientific management school:

For nurses "accountability" in the corporate sense has meant an increasing invasion of management technologies (for example, patient classification systems, nursing process, and nursing audit) into their nursing practice. The rationale for these changes is that they "improve" nursing practice, but the end result may frequently be the increasing alienation of nurses from their work, because they see their work becoming increasingly alienated from its original goal: patient care. (UNA Brief: 1982, p. 22)

Thus it seemed that the duty of nurses to patients was considered to be the hands-on care of patients, and although union representatives saw the need for change it was not the kind of change being implemented by employers.

The duty of nurses to patients was conceptualized as wholly restricted to the employment relationship, yet separate and distinct from the duty of employers to patients. The duty of employers was to provide all of the human and material resources that would ensure that nurses could practice with integrity, and to provide suitable substitutes in the event of a strike. Union members expressed serious concerns about the quality of the services they were able to

provide, and pointed out that there was a great need for patient advocates in the hospital system--a role that nurses wanted to undertake. The Arbitration Tribunal learned from the nurse witnesses that in attempting to serve as patient advocates they met with indifferent responses and were discouraged by their dealings with employers in effecting what they considered to be necessary changes. Commenting on the failure of employers to deal with workplace problems one nurse said: "We feel that if these people are shackled within the present system and are unable to implement change, how can we be expected to do anything about the conditions?" (Arbitration Tribunal Proceedings, 1982, p. 2114).

The Chairman of the Arbitration Tribunal was puzzled by the concept of nurses as patient advocates. He noted that advocacy implied putting a point of view across and would detract from a nurse's objectivity placing him or her in a situation of built-in conflict with employers (Arbitration Tribunal Proceedings, 1981, p. 2125). Viewing the duty to patients as something that includes patient advocacy has the effect of legitimizing an ongoing adversarial approach to the employment relationship, and justifies efforts to spell out that relationship in definitive terms in the collective agreement. Deleting all clauses from the collective agreement that might allow managerial discretion would accomplish such an objective, and this was a manifest goal of the union in negotiations leading to each of the disputes.

The duty of nurses to patients was also clearly conceptualized as distinct from the duty of nurses to the public. The role of the

union was solely to represent the interests of the members, and the interests of the members did not include the interests of the public. The public interest was clearly the joint responsibility of government and employers (UNA Brief: 1982, p. 20). Moreover, the AARN was the official organization whose business it was to take care of nurses' duty to the public at large (Ethier). Hence, in the brief to the Standing Committee on Public Affairs, the union stated: "Our members have not asked us to represent the interest of the public at the bargaining table, nor do we see that as our role" (UNA Brief: 1983, p. 20).

A segmented conceptualization of the responsibilities of nurses to patients, to employers, and to the public would seem to have considerable functional utility for the union. It provides further evidence of an ideology consistent with blue collar types of unionism that strive to alleviate the tyranny of the workplace through collective bargaining and continuous confrontation in the daily operations of the plant. It contains a set of beliefs that permits disassociation from feelings of professional commitment that might interfere with a decision to undertake job actions and strikes. It legitimizes self-interested motives which historically have been suppressed in the nursing profession. Further, the concept of a duty to patients as contingent upon, yet transcendental to the duty of the employer to patients, would serve to lower anxieties felt about civil liability should services be rendered under less than optimal circumstances. It represents a system of beliefs which offers infinite opportunities for sustaining an adversarial relationship with the employer while

denying the possibilities for compromise, cooperation, and joint responsibility for the quality of nursing services. It was evidence of this general system of beliefs which led the Minister of Labour to conclude that there was a distressing cynicism on the part of the union representatives towards the employment relationship (Young).

Lifestyle Issues

The working hours of hospital-employed nurses are characteristically out of step with those of the majority of the workforce. Shift and weekend work can be physically and socially disruptive but in particular, can complicate domestic and child care arrangements. The union sought to normalize the lives of its members, introducing demands designed to maximize the predictability of hours off the job, and to minimize the inconveniences associated with shift work. The parties were sharply divided on these issues in all of the disputes, but especially in the second and third.

The union placed special importance on the issues affecting the hours of work of part-time and casual nurses who comprised approximately one third of the membership. In the first dispute the union pursued a policy of trying to obtain equal terms and conditions (especially fringe benefits) for both full- and part-time nurses, and to secure bargaining rights for casual employees. In the second dispute, the union demanded that in addition to work days, the days of rest for regular part-time nurses be scheduled to prevent the practice of some managers of treating these nurses as casual employees. The union sought to impose financial penalties on employers (e.g., overtime payments) should they require the services of a

part-time nurse on her scheduled days of rest. All of these demands were strongly resisted by the employers.

The employment of part-time and casual nurses permits employers to adopt variable staffing methods giving them more control over personnel costs. The unpredictability for the employer of staffing exigencies such as employee sickness and turnover, coupled with the normal fluctuations in patient care requirements can be managed more efficiently where work schedules are flexible. Faced with shortages of nurses and hospital deficits, many employers were convinced that not only were the cost implications prohibitive, but the scheduling demands of the union were completely unworkable.

Some of the most disputed lifestyle issues were as follows: every second weekend off duty; fewer consecutive working days; no less than two consecutive days of rest; more vacations and statutory holidays; improved maternity and adoption leaves; the ability to refuse overtime requests; posting work schedules four weeks in advance in the 1980 dispute, and one year in advance in 1982. Employers consistently resisted these demands primarily on the basis of the costs involved, but also on account of the increasing stringency that concessions to such requests would place on the management of work schedules and staffing arrangements.

Complaints of nurses about shift schedules and hours of work were not new. With the exception of the historical fact of low salaries, there would seem to be few more contentious issues between nurses and employers than hours of work and shift schedules. Researchers and feminist scholars have amply documented the tolera-

tion by nurses of excessive working hours, unattractive tours of duty, overtime, split shifts, inadequate rest periods, and various other utilization aberrations. The International Labour Organization identified hours of work as the most important problem in the organization of nurses as well as the most important problem in their lives (International Labour Organization, 1960). Hours of work were cited by inactive Alberta nurses as a major factor preventing them from returning to the hospital workforce (AHA Nursing Manpower, 1980). The universality of this problem for nurses seems to suggest that complaining about hours of work might be an occupational norm. Alternatively, it could be argued that the scheduling of nurses' hours of work has been one of the most insensitive and misunderstood management techniques in the history of modern hospitals. In any event, the 1982 Arbitration Tribunal spent no less than five of the sixteen days of hearings listening to the arguments of the parties and expert witnesses on two articles in the collective agreement, namely, hours of work and overtime provisions.

The issue of scheduling the hours of work of hospital-employed nurses exemplifies the difficulty of reaching an agreement between union and employer negotiating teams whose principals are from diverse institutions. Many of the lifestyle issues could have been accommodated more readily by large metropolitan hospitals than by smaller hospitals with their limited staffing pools. The demands of nurses with respect to weekends and shift schedules were probably more amenable to settlement at the local bargaining unit level, but the union would not have agreed to this kind of decentralized deci-

sion-making because it wanted to avoid "sweetheart deals" at all costs (Clarke). As it was, several union locals already enjoyed more favourable work schedules than the one that was ultimately imposed by the Arbitration Tribunal, causing one nurse to say: "We really screwed ourselves on the work schedules" (Dancause).

Summary

An examination of some of the most controversial professional and lifestyle issues in the dispute between nurses and employers provides evidence that the union intended to bring about a redefinition of the employment relationship. The importance attached to the union's demand for professional responsibility committees reflected the determination of nurses to find ways of compelling employers to make changes in the management of hospitals. The arguments advanced in support of the demands associated with professional responsibility appear to have stemmed from genuine concerns about the quality of hospital services to patients. The tactics of the union to gain concessions included allegations of improper management practices which provoked resistive and defensive responses from employers.

The demand that would have eliminated non-nursing duties was prompted more by the desire to restrict output and to avoid exploitation than by the desire to interpret the role of the nurse to the employer. Historical antagonisms between the AARN and the UNA were reactivated when the union proposed to abolish the differential in salary based on registration in the AARN. The refusal of the union to supply essential nursing services during the strikes revealed a conception of a nurse's duty to patients as one that was contingent

upon the physical presence of a nurse in the place of work. When on strike a nurse was said to have no obligation to the employer and therefore no obligation to patients.

Professional issues were at the centre of these labour disputes, but the nature of the demands cannot be said to have been motivated by a desire to enhance or to promote the discipline of nursing. Professional issues were recognized by union leaders as important to certain of its constituency, but on the whole they said they had concentrated on traditional bread and butter issues. One member of the AHA observed: "The union used professional rhetoric when it benefitted them because it assuaged their guilt and convinced the membership that professional issues were at stake" (Cranston). It was the opinion of the union negotiator, however, that most members saw professional demands as appropriate bargaining goals "and for some, they lend an air of respectability to the whole process of collective bargaining" (Renouf). The President of the union summed up the membership's attitude as follows: "Our members are not strong on women's issues or professional issues, but we do want to make gains in inservice education, professional responsibility to patients, health and safety, professional enrichment, and job protection" (Ethier).

The following statements may be made by way of summation:

1. The professional responsibility of nurses constituted a central theme in the disputes and was an issue on which the parties were clearly polarized.
2. The union's demands for professional responsibility committees

reflected profound concerns among nurses with what was perceived as widespread problems in the hospital system, and a desire to improve their working conditions.

3. Arguments of union leaders in support of professional responsibility demands revealed a concept of the employment relationship in which responsibility of nurses to patients was said to transcend the responsibility of nurses to employers and to be contingent upon the physical presence of nurses in the workplace.
4. When on strike, nurses were said to have no obligation to employers and therefore no responsibility to patients, and no legal obligation to maintain services in critical care areas.
5. Responding to medical emergencies during a nurses' strike was considered by the union to be a moral decision for the individual nurse.
6. The scope of bargaining expanded during the six year period primarily by encompassing economic and lifestyle issues.
7. Union values gave rise to demands that were potentially detrimental to the nursing profession as a whole. In particular, at issue was a proposal to remove from the collective agreement a financial incentive for maintaining registration in the professional nurses' association.
8. Union values gave rise to a demand to prohibit nurses from carrying out certain non-nursing tasks and by association, the meaning and scope of nursing tasks.

9. Union values gave rise to demands that would broaden the scope of circumstances in which an employee might refuse the directives of an employer, thereby redefining the employment relationship.

Negotiations

It will be recalled from the review of the literature in Chapter 2 that strikes are sometimes said to be the result of faulty negotiations. This section is devoted to an examination of the negotiations as possible causal factors. One serious difficulty attached to a retrospective assessment of negotiations is that one is dependent on the recollection of people involved at the bargaining table to reconstruct events. As the union negotiator said: "You really had to be there to know what went on" (Renouf). Notwithstanding, it was possible to identify some characteristics of the negotiations from the descriptions of approximately 20 strategic informants, some of whom had kept detailed personal records. These individuals were either negotiators or members of the bargaining teams, and several were involved in more than one set of negotiations.

There were several recurring problems that seemed to have contributed to the development of impasses during negotiations. The source of hospital funding was an ever present consideration influencing the bargaining positions of the parties, as well as their rhetoric and tactics at the negotiating table. Federal and provincial government wage and price controls were mentioned earlier, but these too were without a doubt major obstacles to free collective bargaining. The parties charged each other with bad faith bargaining

from time to time, and the Minister of Labour and his Deputy delivered at least two lectures to them on the poor standard of collective bargaining (Mellors; Cranston). Each party complained about the idiosyncracies of the other's bargaining style, and neither party seemed to trust nor believe the other.

Bilateral Skepticism

Throughout the disputes there existed considerable unwillingness on the part of both parties to believe the demands and arguments of the other. These incredulous attitudes contributed to a general spirit of skepticism towards the collective bargaining process, to mistrust, and to the lack of cooperation. The evidence suggests that there were rarely, if any, moments of serious bargaining where it could be said that the parties perceived each other as equals or demonstrated mutual respect. The union's lawyer informed the Arbitration Tribunal in 1982 that you "can't have that sort of a relationship if you are dealing from a position of subservience... [The AHA is] not prepared to accept the equality of the relationship in the collective bargaining sense" (Arbitration Tribunal Proceedings, 1982, p. 2439).

Several nurses explained to the investigator that historically, the AHA had never really listened to what nurses had to say: "No one at the AHA would ever take us seriously," the first UNA president said (Chinell). Members of the 1977 UNA bargaining team had very clear recollections of the negotiating process, very probably because each of them had been assigned the task of observing and analyzing the remarks and body language of a counterpart on the AHA team. One

of them said: "I remember all the men sitting there with their arms folded, sneering at our demands and ridiculing our team with a 'my-girls-wouldn't-want-that' kind of an attitude" (Gillis). The nurses were offended by the levity observed among the AHA team members over what seemed to them to be pretty important business.

A sense of outrage was not confined to the union side of the table. The AHA was well aware of the intraorganizational turmoil going on within the AARN at the start of negotiations, and as one secretariat member said: "We knew it was going to be a totally new ball game bargaining with the nurses" (Rheault). Evidently the AHA bargaining team was not fully prepared for what eventually transpired. Members were shocked by the extent of the bargaining demands tabled by the UNA; surprised by the fundamental change in the bargaining stance of the union; and puzzled by the anger, hostility, and foul language expressed by the nurses (Mrazek; Rheault). This behaviour seemed so unlike the behaviour of nurses that employers were used to in their work settings that they seriously doubted whether the UNA team properly represented rank and file nurses.

People on the management side of the table believed not only that the UNA bargaining team was not representing the majority of nurses, but that they were actually hoodwinking the union membership. For example, in a Telex to member institutions during the second dispute, hospital administrators were directed to post the AHA's latest offer to the nurses on bulletin boards, "replacing them as often as necessary" (AHA Telex, April 10, 1980), assuming no doubt that union officials would tear down such notices. Again in the

third dispute, the AHA spent \$4000 on advertisements in various provincial newspapers addressed to: "Nurses! What the D.I.B. Report Offers You," the assumption being that union members would not have been apprised of the facts. The president of the union remarked to the investigator that "there is always a perception that we tell the members lies, that is why we sent a copy of the DIB report to every union local" (Ethier).

Managerial chauvinism. Failure to believe in the integrity of the union's bargaining team, almost all of whom were women, stemmed in part from the attitudes of certain AHA representatives, almost all of whom were men. These attitudes were labelled managerial chauvinism--a term intended to imply a combination of stereotypical attitudes of employers towards employees and of society towards women. Evidence that such attitudes existed was found in much of the documentary material examined, and in the arguments used to discredit the demands of the nurses. For instance, members of the AHA secretariat refused to believe that certain lifestyle issues were of real importance to nurses, in particular that the demand for more weekends off duty was a strike issue (Ewart). Even the nurse managers on the AHA negotiating team were offended by the managerial chauvinism of certain key decision-makers and at least one AHA lawyer, who tended to deny the legitimacy of the nurses' lifestyle demands (Fleck; Dolan). Shift schedules and working on weekends, for example, were regarded by these men as inconveniences of the job about which nothing could be done--nurses had known this when they chose to enter nursing. Such attitudes were not restricted to AHA representatives

according to an unidentified newspaper clipping found among the AHA archives: "The nurses knew exactly what they were getting into when they entered their profession. They knew the game, and now they are trying to change the rules halfway through" (circa February, 1982). Among other things, this type of attitude suggests a denial of the legitimacy, purpose, and objectives of collective bargaining itself.

Managerial chauvinism seems to have been operating on a number of other occasions. For example, it would seem to explain: a) the tendency of managers at the 1982 Arbitration Tribunal Proceedings to refer to nurses as "the girls" (see pp. 2088, 2260); b) the opinion that a woman's dual role as a homemaker and nurse should not be a problem vested in the employer (Barrass); c) the belief that if the government had held off a bit longer in the 1977 and 1982 strikes, the union could have been broken (Grothen; Connolly; Lamb); and d) the expressed feeling that it was time to have a showdown with the nurses (Pals). In discussing the attitudes of her male colleagues on the AHA team, one nurse manager remarked that she felt it was part of her role to educate hospital administrators about the realities of the work of nurses "because some of them neither understood nor listened to what the nurses were saying . . . some of the nurses' demands were legitimate" (Dolan).

The concept of managerial chauvinism serves to illuminate the problems that arose in the third dispute in response to union allegations of improper management practices. Attitudes hardened substantially under a barrage of union accusations with respect to inadequacies in patient care. The AHA negotiator said that one of his

biggest problems was the extreme provocation felt by managers at the charges made by the nurses (Barrass). It was his opinion that many of the allegations were unfair, having little foundation in truth. Bargaining dynamics such as these were counterproductive, serving merely to polarize the parties rather than to achieve concessions. For example, after eight months of negotiations in 1982 there were 220 items which remained to be settled.

Authority to bargain. Another source of skepticism among union leaders towards the negotiating process was rooted in their conception of the AHA's authority to bargain. The union argued that as hospitals were dependent on the government for funding, it was unreasonable to conclude that full authority on economic issues would, or even could, be delegated to an agency like the AHA. It was the opinion of Renouf that in view of the amount of money spent on nursing and other hospital employees' salaries, no government would permit an independent organization to determine unilaterally the expenditure of such a large portion of the provincial budget. The Alberta government, he argued, was content to allow the AHA to settle most of the issues "without selling the farm" but that it was only interested in the economic issues: "The government's role is to pull all the strings while protecting itself from the flak" (Renouf). Hence, for political reasons the AHA was said to be incapable of exceeding the fiscal guidelines on wages: "We have no problem with the people at the AHA, but what we do object to is dealing with the monkey rather than the organ grinder," Renouf remarked. To the membership, Renouf said:

The structure of hospital bargaining in Alberta today is a recipe for bad faith bargaining. Just a few weeks ago at its annual convention, the hospital association was complaining publicly that it lacks the power to run the hospitals, and that it lacks full budgetary control. Yet these are the people the nurses are forced to negotiate with. ("Hospital negotiations to go to conciliation board," 1980, p. 1)

As the newly appointed union negotiator, one of the first questions Renouf raised at the meeting of bargaining teams was why there was no government representative at the table (Owen). The AHA's position on the model of bargaining implied in Renouf's question, has always been that it is independent of government in all of its activities and does not contemplate the inclusion of government representation at the collective bargaining table (Coombs; Knight). Despite assurances of complete autonomy from government, the union continued to consider the AHA as a false front for the government, an opinion that was shared by other observers including the Edmonton Journal (Heise).

Attitudes towards intermediaries. Mutual feelings of mistrust were generalized to several of the mediators and conciliators in the three disputes. Ostensibly, the role of mediators and conciliators was to assist the parties to reach agreement on contentious issues while remaining neutral in the process. The neutrality of the intermediaries was seriously doubted by the parties, each perceiving that the mediator or conciliator was biased in favour of the opponent, or in some cases, was actually incompetent. Commenting on the 1977 conflict, the union negotiator said: "Conciliation was a joke--the conciliator was in league with the AHA and tried to get us to drop our demands" (Donahue). Renouf was much less complimentary

about another intermediary saying: "He was a rednecked, inappropriate appointee" (Renouf).

On the management side, one conciliator was reported to have been not only a Liberal, but married to a nurse and therefore in league with the union (Cranston). This same conciliator was said to have drafted a clause for inclusion in the collective agreement which, in effect, would have been better than the union's original demand (Currie). Finally, some members of the AHA team were amazed at what appeared to them to be evidence of irresponsibility among senior bureaucrats in the Department of Labour who kept urging them to increase the money offer to the nurses (Fleck; Dolan). The phenomenon of disparaging attitudes towards third party intermediaries reveals the extent of the skepticism and pessimism that sometimes engulfed the parties. While feeling unable to move forward with the business of settling items on the bargaining agenda, neither party seemed to have held out much hope that anyone else could assist them to their satisfaction.

Idiosyncratic Bargaining

A common convention in collective bargaining is for unions to state their initial salary demands in terms that exceed the point at which they expect to settle. Similarly, employers do not generally expect their initial offers to be accepted by unions without a certain amount of upward modification and trading among items. The parties thus build some flexibility into their demands to facilitate the negotiating process. The opening position of the union in all of these disputes so far exceeded convention as to be considered ridicu-

lous and indeed, unbelievable by the AHA negotiating teams. At each successive round of bargaining, the scope of demands and the size of the salary expectations increased--a situation which did not augur well for expeditious settlements. As one AHA negotiator said: "When you have as many as 364 demands, some of which go beyond the realm of working conditions, how can you begin to bargain?" (Barrass).

Strategic informants identified various characteristics in the bargaining styles of their adversaries which they said contributed to the breakdown in negotiations. Union members charged that the AHA habitually refused to make a money offer at the start of negotiations. On the other hand, the AHA representatives felt frustrated by the union's propensity for keeping all of its demands on the table, even those that were assumed to have been settled. Each party apparently persisted with its idiosyncratic style which led to procedural difficulties and minimal progress.

In the first dispute, both negotiators claimed that they had no personal problems with the other's style of negotiating, despite the impasse that ultimately developed. Indeed, they understood each other well enough to reach an accord within four and a half days of bargaining the following year (Donahue; Grothen). Nevertheless, the union refused to drop any of its demands and the AHA refused to make a money offer. The nurse on the management team seemed to think that as the nurses wanted to strike they were unwilling to drop any of their demands (Mrazek).

In the second dispute, both parties came to the bargaining table with a newly appointed negotiator. Not much was known about Renouf

as the union had recruited him from Ontario. On the other hand, the AHA negotiator was a former union man and reported to be tough and unconciliatory (Dolan; Fleck; Mellors; Connolly). The initial dossier of demands presented by the nurses was later described by a member of the AHA secretariat as a 170-item shopping list (Rheault). The parties adopted a hard line from the very first bargaining session, and an aura of mistrust and hostility prevailed.

The bargaining style of the new union negotiator was described by an AHA representative as a juggler trying to keep all balls in the air: "The trouble with Renouf is that he takes everything and drops nothing when he is negotiating. He simply cannot be trusted" (Grothen). Another AHA representative described the final moments before a settlement was reached following ten days of strike and a marathon bargaining session. The parties were very close to a settlement when Renouf refused to appear at a scheduled meeting unless the AHA agreed to improve the vacation allowance, an item that had previously been settled (Fleck). Similarly, in the third dispute, the union was determined to improve on the recommendations of the DIB report by elaborating on its earlier demands (AHA Press Release, February 24, 1982). Thus, the union's tendency to keep all its irons in the fire was considered by the AHA to be close to bad faith bargaining (Barrass).

The expectations of the AHA as to the order in which bargaining items were to be settled was a constant source of friction for the union. Indeed, the failure of the AHA to make a money offer resulted in the refusal of an Arbitrator to deal with the dispute between

three provincially owned hospitals and their nurses' locals under the Public Service Employee Relations Act (Schuler, 1980). The rationale for the stance of the AHA on the timing of its wage offers was communicated to member institutions as follows:

The AHA has not tabled a firm salary offer or discussed money (costable) items to date because association negotiators believe these items cannot be realistically discussed before other, non-costable items which can dramatically effect [sic] the total cost of compensation have been settled. Without knowing the impact on compensation of non-costable items, no salary offer would be realistic and any unrealistic offer is a disservice to nurses and employers alike. Settling the non-costable items first will provide a foundation for a strong equitable agreement. But to start with a salary proposal and work down would be similar to building a house starting with the roof. (Background to current employee compensation negotiations: 1979)

The fundamental conflict over the procedural aspects of their negotiations became a formula for intransigence at the bargaining table. The unsuccessful attempt of the 1980 Conciliation Board to bring the parties to an agreement over the salary issue caused the Chairman to write:

As a result of these intransigent positions this Board has experienced a greater difficulty in dealing with this issue than is the case in most other conciliation board proceedings. This difficulty has been somewhat compounded by a lack of evidence to substantiate the positions the parties were adopting. (Lucas, 1980, p. 17)

However, the AHA made a considerable effort in the 1982 dispute to break away from this pattern of interaction at the bargaining table. Individuals in the AHA secretariat were determined to create a better climate, while the AHA Employee Relations Committee decided that the expertise of its negotiator was a critical factor (Heise). Accordingly, Ken Barrass who had served as consultant to the Alberta Association of Registered Nurses in the 1960s, was hired to undertake

the negotiations on behalf of the AHA. Subsequently, the AHA made a salary offer much earlier in the proceedings than in previous negotiations, but the nurses dismissed the offer as "garbage" and immediately applied for a strike vote (AHA Memorandum to Board Chairmen and Administrators, December 15, 1981).

Failure of union leaders to recognize changes in the position of the AHA occurred more than once. The Minister of Labour observed this tendency in his dealings with the parties during the second dispute (Young). The skepticism would seem to have become so entrenched that opportunities to find a compromise were missed and perhaps not even contemplated by union leaders in their determination to satisfy the membership.

Government Intervention

The role played by the government and its agents in these disputes was without doubt one of the major sources of difficulty for both parties. The government as initiator of the rules; monitor and facilitator of the collective bargaining process; last dollar funder; and protector of the public interest ensured a potential, if not direct, presence at every phase of every round of the negotiations. The government intervened in every dispute, decreeing that a collective agreement would be imposed on the parties since they did not appear to be able to resolve their conflicts otherwise. Both parties persistently and vehemently decried the so-called interference of the government in their disputes in spite of the advantages to be gained by such intervention. It would seem to have been the government that took both political and financial risks by intervening, while the

parties were spared further acrimony, public disapprobation, and responsibility for difficult decision-making. It was the opinion of the then Executive Director of the AHA that when the government intervened in the 1977 strike, it "cut its own throat" and set the stage for all future disputes (Ross). One AHA negotiator remarked: "Every time the government intervened, it cost them a bundle" (Grothen).

By virtue of government intervention, the union received an economic bounty that it most probably could not have achieved in a situation of "free" collective bargaining. Through the process of interest arbitration, nurses received awards in excess of what was legally permissible in 1977 and what was institutionally feasible in the third dispute. As well, the evidence overwhelmingly suggests that government intervention prevented the collapse of the union in 1977, the collapse of the strike in 1982, and what would most certainly have been the loss of leadership credibility within the union. One benefit to the AHA was that it avoided the embarrassment of having to explain to member institutions the necessity for relaxing its rigid fiscal and ideological positions on economic and substantive issues.

The shadow cast by the government over the collective bargaining activities of the principal actors was omnipresent. For the AHA, there was always the uncertainty as to the willingness of the government to finance extraordinary settlements if needed. For both employers and union, there was always the possibility that the accidental death or misadventure of a patient during a strike would

result in government intervention. Indeed, after the first dispute it became clear to the parties that it was not so much the question of if the government would call a halt to their economic warfare, but when it would do so. These uncertainties continually influenced the tactical decisions of the parties.

There were indications that the parties applied for conflict resolution services in order to maximize their tactical advantages. The attempt by the AHA to obtain a settlement through binding arbitration in provincially owned hospitals in the second dispute provides one such example. Applying for third party assistance took the pressure off the parties for serious, good faith bargaining, and allowed negotiators to explain to their principals that they were doing all in their power to prevent a work stoppage. It also tended to prolong the total period of time spent in securing a new collective agreement.

Delays and sporadic negotiations characterized all three disputes. The period between the start of negotiations and the signing of the final document was eleven, eight, and ten months respectively, compared with a mere six weeks for the negotiated settlement of 1978. Delays in the process of collective bargaining generated impatience among nurses and a need to know what was going on (Chinell).

Unwittingly or not, the novice Minister of Labour prolonged the negotiations in his personal efforts to expedite an agreement during the second dispute. He appeared to withhold the recommendations of the first conciliation report, and later granted two deadline extensions for the completion of the report of the Conciliation Board.

The Minister's actions were interpreted by the union as the tactics of delay, prompting the nurses to keep their dispute in the public domain through job actions (e.g., disregarding hospital uniform policies), demonstrations, letter writing to the press, and political lobbying. Meanwhile, it gave the union plenty of time to orchestrate its strike plans, because as one union organizer said: "It would be silly not to take out insurance" (Hill, 1980).

Summary

In this section several characteristics of the negotiations were identified as having contributed to the development of impasses at the bargaining table. In every case, negotiations extended sporadically over a period of more than eight months; third party conflict resolution procedures were employed; and the Conservative government intervened in the strikes ordering nurses to return to work. The evidence can be summarized as follows:

1. The general tone of negotiations was characterized by skepticism and mistrust, and was fostered by attitudes of militant unionism on the one side, and managerial chauvinism on the other.
2. Skepticism among union leaders towards the negotiating process was based primarily on the assumption that the AHA possessed limited authority to bargain independently of the provincial government.
3. Skepticism among members of the management team stemmed from beliefs that: (a) union leaders were unrepresentative of rank and file nurses; (b) nurses were generally misinformed about the issues in dispute; and (c) lifestyle issues identified by nurses

were fixed and integral aspects of the nursing job and should not be conceded.

4. The bargaining styles of union and employers' negotiators were incompatible, which led to disagreements on procedural matters.
5. Union negotiators were reluctant to abandon any of their demands, including items upon which agreement had already been reached.
6. Incredulous attitudes of the parties to each other were generalized to third party intermediaries.
7. Exhaustive use of mediation and conciliation mechanisms in every dispute reduced the need for serious, good faith bargaining.
8. The probability of government intervention in the second and third strikes had a chilling effect on negotiations.

Institutional Resources and Constraints

Bargaining power, according to Craig (1983), is defined as the ability of an actor in the industrial relations system to achieve goals despite the resistance of others. In this section, certain institutional features of the union and management organizations are examined to determine the extent to which they served as political resources or constraints in the pursuit of bargaining objectives. Some theorists have assumed that power is the essence of bargaining and that it can be conceptualized as a structural element in the bargaining relationship (Bacharach & Lawler, 1981). Much of the data suggest that several empirical indicators of bargaining power, or lack of bargaining power, can be identified as having contributed to the conflict and to the willingness of the parties to engage in economic sanctions.

Institutional resources and constraints is a term used here to refer to certain organizational characteristics that served to bolster or to detract from a party's bargaining power. For instance, there were significant differences between the UNA and the AHA in the composition and cohesion of the membership which, under the pressure of a pending strike, became more or less advantageous in the pursuit of bargaining goals. There were differences in the visibility and structure of leadership in the two organizations; the parties appeared not to be equally adept at managing the media; and neither party seemed to be able to influence external coalitions sufficiently to sustain their economic warfare to its logical conclusion.

Membership Characteristics

Unlike all other major unions bargaining with the AHA, the UNA's membership consisted of a single occupational group. Registered, psychiatric, and graduate nurses comprised the membership and they shared similar educational backgrounds, socioeconomic status, occupational identities, and work experiences. The membership was almost entirely female and understood each other's problems, needs, and demands, facilitating the demand-setting process and the task of representation in negotiations. All demands from the local bargaining units were considered, debated, and if deemed important to any particular constituency, were forwarded to the bargaining team. The union prided itself on the fact that members were free "to speak their minds," and could be assured of representation whether in negotiations or in grievance handling (Chinell; Ethier).

In addition to occupational homogeneity, nurses comprised the

single largest unionized work group in the hospital industry. They held unequalled potential power to bring about major disruptions in the hospitals if they chose to withdraw their services. The dependency of hospitals on nurses to sustain their operations stems from two factors. First, patients are not usually admitted to hospitals unless the treatment program requires the services of nurses. People can be treated in the community if there is no need of nursing care on a 24-hour basis. Second, nurses occupy a central position in the complex organizational milieu of hospitals and are continuously present both in time and space. Other health disciplines have short, discontinuous contacts with hospitalized patients and their activities are coordinated on the inpatient unit by nurses (Mauksch, 1960). Moreover, nurses assume major responsibility for implementing medical directives for the treatment program of patients. Withdrawal of nurses from this pivotal role in the total operation causes a complete cessation of normal activities unless substitutes can be found. In all of the disputes, management nurses were substituted for their subordinate colleagues and assisted by auxiliary nursing personnel, but not without significant cut backs in the scope of services to patients.

When substitutes with equivalent skills are in short supply, as they were in these strikes, the bargaining power of nurses is significantly enhanced. Thus, nurses occupied what Dunlop (1958) would describe as a strategic position both in the technological structure of the enterprise and in the labour market. Occupational homogeneity within the union, combined with the strategic position of nurses both

in the hospital and in the labour market, must be considered formidable power resources. However, as Bacharach and Lawler (1981) suggest, such resources should be regarded as potential power in that these factors alone were not sufficient to cause an impasse at the bargaining table, or indeed a strike.

Membership in the AHA, in contrast to the union, was by local institution as represented by hospital boards of trustees. Member institutions, as noted in Chapter 5, often had little in common and differed on a number of dimensions including size, power, location, type, and scope of services offered. Moreover, individual trustees and administrators were drawn from disparate occupational backgrounds and almost all of them were male.

The history of the AHA revealed that there had been longstanding divisions within the membership ranks, particularly between large and small, urban and rural hospitals. Tensions also existed between member institutions and the decision-making structures of the AHA, and between these bodies and the AHA staff, or secretariat, as it was called. The mandate of the Employee Relations Committee (ERC) for example, was to develop policy and to recommend bargaining guidelines to the AHA Board of Directors, but from the point of view of the secretariat, the ERC was perceived as wanting to administer the collective bargaining program, rather than to focus on policy development. There was resentment among the 1980 bargaining team members when the report of the Conciliation Board went directly to the ERC without first being seen by the team (Fleck; Mellors). Again, in 1982, the ERC overturned a secretariat decision in the matter of the

appointment of the AHA negotiator to handle the UNA contract (Heise; Owen; Barrass).

Membership in the union was an individual phenomenon notwithstanding the organization of local bargaining units, whereas membership in the employers' association was an institutional phenomenon. The occupational homogeneity of union members, their strategic role and contribution to the enterprise, and labour market factors can all be regarded as political resources favourable to the union in these labour struggles. On the other hand, the employers' association was characterized by a disparate membership, intraorganizational schisms, and tensions that were unlikely to foster solidarity in the event of interorganizational conflict. Such characteristics can be regarded as political constraints, or at the very least, potential weaknesses in the management armamentarium.

Leaders and Leadership

There was little doubt in the minds of both union and management informants that all of the most prominent leaders in the union since 1977 had been strong and right for the time of their tenure. Union members acknowledged the need for effective leadership; leaders had to be people who were not about to back down under pressure. As one of them said: "We would not have got anywhere without strong leaders" (Dancause).

Chief executive officers of the union. During the six year period two men occupied the top executive job in the union, and each brought very different yet effective leadership styles to the position. Neither of the two was a nurse, and Renouf had had no previous

experience with nurses' unions. Both were described by union members as having the necessary labour relations expertise to run the union (Mearns; Clarke; Dancause). Management people placed a great deal of importance on the fact that these leaders were men and non-nurses in explaining why the union was adopting a blue collar model of unionism (Mrazek; Rheault; Embury). There was thus a general perception among employers that nurses had allowed themselves to be led in an undesirable direction. Union members argued, however, that hiring men as their negotiators had strengthened their bargaining power because, previously, the AHA had taken advantage of the former director of collective bargaining on account of the fact that she was both a nurse and a woman (Bennett; Ewart; Charbonneau).

Robert (Bob) Donahue was the first of the two chief executive officers. His role in union affairs has been described in detail earlier. He seems to have been the most visionary of the leaders, and it was largely attributed to him that the union survived its precarious infancy during the first year as an independent entity. He was without doubt the prime mover in determining the direction and course of action taken by the union in that formative year. He orchestrated both the secession from the AARN, and the first strike; he was the chief architect of the union's constitution; and he designed the basic organizational structure which prevailed throughout the six year period, albeit with minor modifications.

Donahue possessed many of the skills of successful corporate executives (Mintzberg, 1983). He managed both the internal and external coalitions and emerged as the individual with the most

knowledge and influence in union affairs. He had boundless energy and worked relentlessly over long hours; he had a talent for organization and rapid decision-making; he was even-tempered even under attack, and a fearless risk-taker. His propensity to challenge entrenched rules became something of a tour de force in the union as his attitude was, "you ought to try it because you might win," which, as one nurse observed, contrasted sharply with that of his predecessor whose attitude had been, "you ought not to try it because you could get into trouble" (Bennett). He risked his own and the union's survival in calling for the strike in 1977, and again when he threatened to expand that strike knowing full well that he could not sustain it (Donahue).

Like many charismatic personalities, Donahue generated a few myths (for example, "he was like a Pied Piper"; "a real Dr. Jekyll and Mr. Hyde"; "he was into mind control and metaphysics"), but his personal qualities enabled him to identify the needs and expectations of his followers, and rally them to a cause. In addition, he had been well trained by Chapman in the work-related issues and problems of nurses. He survived a challenge to his leadership at the end of 1977 from the two employment relations officers, both nurses and one of whom was also a lawyer. Those employment relations officers were concerned about the general direction in which Donahue was taking the union and the extent of his formal powers, but the crisis was resolved when the President requested and obtained their resignations (Donahue; Chinell; Bennett; Gillis). This incident signalled the decline in Donahue's control within the union, and he admitted that

the 1978 negotiated agreement marked the end of his independence as Chief Executive Officer (Donahue). The primary locus of control within the union was transferred to the UNA Executive Board following the election of officers and the ratification of the constitution at the first Annual Meeting in 1978. Claiming loss of interest in his job, Donahue resigned in the spring of 1979 (Donahue).

Donahue's successor was Simon Renouf whom the UNA Executive Board selected from a short list of many applicants for the job. During the interview process, the Executive Board and applicant discussed the question of power and control within the union to ensure that there was compatibility of views on this critical point. It was agreed that the Chief Executive Officer would serve as a resource to the policy makers; an implementer of policy; director of the staff; administrator; and negotiator (Renouf). Many management observers viewed Renouf as the most influential leader in the union and if not the head of the union, at least the power behind the throne. "Most people think I am the head of the union, but I am not" Renouf explained to the investigator. In any event, it was quite clear to the members that Renouf took his orders from the President and the Executive Board (Clarke; Dancause; Chinell; Ethier).

Renouf assumed the title of Executive Director and became a major force within the union. He was articulate, personable, a hard worker, and said to keep a tight rein on the employee relations staff (Grothen). He undertook all of the behind the scenes research for union policy development including the economics of the labour market and trends in industrial relations. According to most commentators

he was an astute union politician whom no one under-estimated, least of all the AHA. His advice was not necessarily taken by the UNA Executive Board, but he made sure that it was informed of all the angles, presenting his case persuasively (Dancause). Renouf was publicly in favour of closer ties with the labour movement (Renouf, 1980a), but throughout the period under study, the union steadfastly resisted any such affiliation with other union organizations.

Union presidents. During the six year period under investigation the union presidency was occupied by two women. Neither the first president nor her successor had any formal education beyond a diploma in nursing but both were highly respected as competent nurses. It was important to the membership, according to Ethier, that the President be perceived as a good nurse (Ethier). Gurty Chinell and Margaret Ethier had both been involved with union affairs as elected representatives and served on the provincial negotiating team before being elected to the presidency. Both were fearlessly outspoken leaders, highly visible, and champions of democracy within the union.

Gurty Chinell had been a head nurse for some fifteen years and spokesman for nurses vis-à-vis the Red Deer General Hospital Board as far back as the early 1960's. She was a competent first line manager (MacPherson) and a popular unionist, although evidently not considered one of the most militant. She was said to have taken many of her cues from Donahue and formed a strong partnership with him in steering the union through its eventful first year. Their leadership styles were described as complementary (Bennett; Dancause; Clarke).

According to one of the employment relations officers, Chinell was never quite forgiven for being on vacation during the first strike (Mearns), but whether that played a role in her failure to be re-elected to a second term is not known.

Margaret Ethier campaigned in a personal way for the presidency and was elected by a small majority at the Annual Meeting of 1980. Ethier was a feminist and militant unionist willing to take a strong, aggressive, and public stand with respect to any person or institution that presumed to tell nurses what they could or could not do. More than any other leader she promoted union ideology, fostering the distinctive image of the UNA as a militant trade union. Like Chinell before her, she formed a strong, complementary partnership with the Executive Director on whose labour relations expertise she was heavily dependent. She was single minded in her representative role, she ran good meetings, was responsive to the membership, and attentive to procedural matters: "We are great on detail in this union, and if we don't like something we change it," Ethier commented to the investigator.

Leadership succession. The patterns of leadership succession within the union and the AHA are illustrated in Table 8. These patterns suggest that the UNA and the AHA differed significantly in the structure of leadership and in the stability and continuity of leadership succession. The partnership of leaders in the union consisting of president and chief executive officer changed with each strike, but they changed in ways that assured stability and continuity in union policy. One of the partners remained in place for each

Table 8

Leadership Succession in the United Nurses of Alberta and the Alberta Hospital Association for the Years in which Strikes Occurred.

<u>United Nurses of Alberta</u>		1977	1980	1982
President		Gurty Chinell	Gurty Chinell	Margaret Ethier
Chief Executive Officer and Negotiator		Bob Donahue	Simon Renouf	Simon Renouf
<u>Alberta Hospital Association</u>				
President		Roy Deyell	Jack Davis	Bud Pals
Chairman, Employee Relations Committee		Ed Knight	Barry Skinner	Les Roberts
Executive Director		Murray Ross	Jim Henderson	Don Macgregor
Spokesman		Verne Rheault	Verne Rheault	Bob Heise
Negotiator		Tom Grothen	Bob Owen	Ken Barrass

of two successive strikes, while a new leader appeared before each strike in time to contribute to the demand-setting process and the strategies of the negotiating teams.

The structure of the leadership in the AHA was vastly different from that of the union. There were at least five people who had opportunities for directly influencing the course of events: the president of the Board of Directors, the chairman of the ERC, the Executive Director, the spokesman (who was also in charge of the labour relations program), and the negotiator. Leadership at the AHA was therefore multiple, diffuse, and hierarchical. Moreover, the leadership underwent both routine and incidental changes such that only one of the 15 men remained in place for more than one strike, namely the AHA spokesman in 1977 and 1980. The AHA leadership lacked continuity, which meant that all but one person was new to his role in each dispute and was thus inexperienced in handling interorganizational conflict of the magnitude of a province-wide strike.

Negotiating Structures and Process

The negotiating structures of union and management were similar in a number of respects, but the processes by which the parties established their demands and the degree to which authority was delegated to negotiators differed considerably.

The union. An organizational chart of the union is presented in Figure 5, in which the structures for handling collective bargaining activities are illustrated. Members of the union's negotiating team were drawn from the elected representatives making up the 21-person Executive Board, and included the President, the Executive Director

and one representative from each of five provincial districts. The negotiating team was thus composed of a team of elected and powerful people to whom the membership had granted full authority for decision-making at the bargaining table.

A detailed description of the union's demand setting procedure is presented here, as it serves to illuminate some of the findings relative to the problems of bargaining discussed earlier, as well as to demonstrate the powers vested in the union's bargaining team. The process of demand-setting within the union was systematic and thoroughly democratic, such that the control exercised by the negotiating team over bargaining strategy was manifestly grounded in grass roots majority opinion. The process began at the local level where members met and stated their needs relative to improvements in the terms and conditions of the collective agreement. The locals forwarded their demands to the negotiating committee which sorted, collated, and added its own demands. The demands of the negotiating team reflected union policy and were often derived from the outcomes of grievance arbitration during the term of the contract.

A demand-setting conference was then convened to which approximately 200 voting delegates were elected on the basis of one per local, and one per 50 members. The larger locals, like the corresponding hospitals, tended to be more influential than smaller locals. The demands were discussed and voted upon one by one, and again as a final package. The package of proposals was then returned to the locals for presentation to the membership and was considered accepted if supported by two thirds of the members present at the local



meetings. Finally, if a majority of locals indicated acceptance of the proposals, these then became the mandate of the bargaining team.

This system of demand-setting was designed to overcome some earlier problems of membership participation, and as Renouf said in response to a dissident nurse: "If any member missed out on having her input, it was not for lack of opportunity" (Letter to Edmonton Journal, December 7, 1981). In effect, the demand setting process gave great authority and power to a small, closely knit group of leaders who controlled not only decisions at the negotiating table, but also the information released to the membership. Interpreting developments at the bargaining table to the members, as well as the moods and wishes of the members to the employers, was crucial to the team's credibility and effectiveness. As one former team member said: "We realized the extent of the power of the negotiating committee over the membership. We could sway them any way we wanted provided we gave good reasons" (Charbonneau). It was, therefore, a source of frustration to the union's team to find that its AHA counterpart enjoyed comparatively less discretionary power and status within the AHA organization (Renouf; Chinell).

The employers' association. The AHA negotiating team consisted of a hospital trustee from the ERC, several senior administrative personnel from member institutions, including one or two directors of nursing, and a secretariat negotiator. None of these people held elected offices in the AHA, nor could any of them be said to have had organizational power and prestige equal to their counterparts in the

union. Not only was the negotiator the most junior member of the AHA leadership hierarchy associated with the labour relations program, but the job was said to have been an unenviable lot. It had no status, according to several informants, it was stressful, insecure, underpaid, and accountable to 164 bosses, i.e., the member institutions (Currie; Connolly; Barrass; Heise). Moreover, it was generally assumed by these informants that the AHA could not attract top flight negotiators to work under such conditions of employment.

The process of preparing for collective bargaining within the AHA organization was not nearly as systematic as that of the union, nor as open to such widespread membership sanction. It started with a memorandum to member institutions, soliciting suggestions for modifications to the collective agreement, and this was followed by discussions at the regional level. Recommendations were compiled by the secretariat, and standardization for all renewable collective agreements, whether for nurses or other hospital employees, was undertaken by the Joint Resource Committee (see Figure 3, p. 93). On the basis of the work of this committee, the ERC established bargaining guidelines for the various negotiating teams.

Authority to bargain within the guidelines was delegated to the negotiating teams but consultation with various key people was customary. In the 1977 dispute, neither AHA negotiator nor any employer had authority to negotiate salary increases beyond the federal anti-inflation limits, and as the nurses' salary demands were six times in excess of these limits, very little bargaining went on at all. As one editorial writer observed, the nurses' demands were

"pie-in-the-sky" and the AHA clung to the guidelines, proving that wage and price controls made a shambles of collective bargaining (Edmonton Journal, August 26, 1977).

An inherent weakness in the multiple and hierarchical decision-making structures of the AHA was realized during the second dispute. Under the stress of an impending strike in 81 hospitals, the authority of the bargaining team was undermined and the normal channels of communication were by-passed as additional actors were drawn into the negotiations. The strike deadline approached and the AHA came under extreme pressure to improve its offer to the union. Individual hospital boards urged a better offer, the Department of Labour officials urged a better offer, and the Premier of the province allegedly directed the AHA to settle at any cost (Rheault). Notwithstanding these pressures, the ERC and the AHA secretariat continued to resist the union and its demands. Indeed, the Executive Director had earlier launched a campaign within the AHA regions in an effort to deflect the "softening" trend of hospital boards wanting to give the nurses more money (Rheault). As the pressure mounted, more people were brought into the decision-making process while the negotiating team was relegated to the sidelines, serving only as a resource to the substitute negotiators (Mellors). There were too many people trying to make names for themselves, according to Rheault, including the novice Minister of Labour who had become involved in the dispute on an "eyeball-to-eyeball" basis (Young, 1980, p. 401). As the former Executive Director noted, the AHA had become a divided house with its power to withstand either the

pressure of the union or of its own internal critics eroded (Ross). The willingness of nurses to defy the government's back-to-work Order and the personal involvement of the Minister of Labour (among other factors) resulted in an unprecedented settlement for the union. The union President observed: "It was a beautiful strike" (Chinell).

The employee relations program at the AHA came under considerable criticism from its members as a consequence of its difficulties in the 1980 strike. In an effort to invest greater authority in the bargaining process, member institutions abandoned their rights to local ratification of agreements in favour of central ratification by the AHA Board of Directors. Additionally, the AHA hired a management consultant as negotiator for the forthcoming round of bargaining with the UNA. The negotiator reported that he had been entirely satisfied with the scope of authority delegated to him by the ERC, and that if he had required greater power he would have requested it (Barrass). These changes in the delegation of authority to bargain in 1982 served the Association well from the standpoint of yielding little of substance to the union, but an impasse in negotiations was reached earlier than ever before. Changes in the labour legislation entitled the union to conduct a strike vote without prior conciliation procedures, an opportunity that it seized within two months of the start of negotiations.

Organizational Cohesion

An important indicator of strength and commitment to a position in the event of interorganizational conflict is the appearance of solidarity among the participants in the face of opposition. As

noted earlier, the history of the AHA demonstrated that there had rarely been unanimity or cohesion among its heterogeneous member institutions. Nine of the largest hospitals in the province consumed more than 50 percent of total hospital expenditures, and the boards of these institutions expected to have commensurate representation on bodies like the ERC. As this position had rarely been accommodated, there was less than complete satisfaction with representation in collective bargaining. Membership cohesion was a source of uncertainty for the AHA Board which had neither the mandate nor the will to require a united front among member institutions. The sole criterion for exercising any form of coercion was the denial of membership in the event of non-payment of annual fees to the Association.

A major constraint in the promotion of membership solidarity for the AHA was a fundamental incompatibility in two of its organizational goals. Representation in collective bargaining required that decisions be made in the allocation of scarce resources for a diverse group of hospital boards while acknowledging their freedom to manage those resources. This dilemma for the AHA was succinctly expressed by one of the executive directors in a letter to an administrator:

AHA has to undertake some educational initiatives regarding some rather outdated labour relations practices still adhered to by some of our members. I also know you are aware that such initiatives are at odds with the attitude on the part of many of our members that AHA's mandate is limited to protecting each hospital's license to go its own way without interference from AHA or the government. (Letter signed by Jim Henderson, April 2, 1980)

As a federation of organizations, loyalty to the common effort was entirely voluntary, and although there was potential for hospital

boards to break ranks, none in fact did in any of the disputes (Heise). Nevertheless, all levels of the decision-making structure were susceptible to informal criticisms and pressures from the many constituent groups.

The union, on the other hand, had many more means at its disposal for promoting solidarity in the face of strong opposition. Not only were the individual members homogeneous and tied by occupational culture and union ideology, but the outcomes of bargaining were expected to affect every one of them equally and personally in the pocket book, in working conditions, and in their lives off the job. Not all staff nurses being represented were members of the UNA even though they all had to pay dues under the Rand Formula, and like most unions, the UNA had its share of apathetic members. For example, the 1982 Arbitration Tribunal was informed that of approximately 9000 union dues payers, only 7000 were actually members (Arbitration Tribunal Proceedings, 1982, p. 44). Apathetic or not, as the Executive Director remarked, the average rank and file apolitical nurse paid close to \$300 per annum in union dues, and she expected that to be translated handsomely into union services and return on investment (Renouf).

Organizational mechanisms in the union were designed to foster agreement and cohesion among members. Information flow was highly controlled through efficient networks coordinated by key players during the strikes. For example, district representatives on the Executive Board played central roles in coordinating and communicating bargaining developments (Ethier). The information networks were

a source of great pride within the union and had been based on the telephone fan-out systems of the hospitals' own disaster plans. Much to the chagrin of administrators, nurses often knew the latest news on the state of provincial negotiations before their employers. Breaking ranks was discouraged by peer pressure, and local union executives were entitled to penalize any nurse who crossed a picket line. Union membership could be revoked for any one of 13 offences should a written complaint be received and the "accused" be found guilty pursuant to a disciplinary hearing (UNA Constitution: 1981, Articles 5.10, 5.11).

It was generally conceded by various informants that the union was well organized and administered, and that it had been effective in mobilizing its members and promoting solidarity during the strikes. In some ways it was more effective than the AHA, for example, in processing its demands, in delegating authority to bargain, and in its internal communications. It was also more effective in using the media to its advantage especially in the first and second strikes, but like the AHA, it was unable to impress either the government or the medical profession that its disputes should be allowed to continue until a negotiated settlement was achieved.

Influencing the External Environment

Strikes in Alberta usually attracted media coverage but these strikes were particularly newsworthy and received a great deal of exposure in the press, on television and on radio. The participants made much use of these important resources as means of strengthening their bargaining power in negotiations. Media coverage provided an

unsystematic and approximate measure of public opinion, but the policy makers monitored editorial comments and letters to the newspapers quite closely, as did the parties themselves.

Public image. The AHA hired a public relations firm in 1977 to advise its decision-makers on media relations, and to coach its spokesman. According to Murray Ross who was the Executive Director at the time, the use of external consultants had effectively strengthened the AHA's position in the first strike, especially in the matter of managing the media and projecting a public image (Ross). As a voluntary association of hospitals, the AHA rarely sought political visibility and could not be described as having a distinctive public image. The public was not well informed of the role of the AHA in the health care system according to a Gallup Poll commissioned in 1980. Of the 1050 Alberta respondents, 61.7 percent said they had heard of the AHA but 53.7 percent could not name any of its activities, and nearly 13 percent thought that it was a department of the government (Report of the Ad Hoc Committee: 1980). The new AHA Executive Director, Jim Henderson, was hired on the understanding that he would promote the visibility of the Association and take a more aggressive stand vis-à-vis the government, but during his short tenure, which included the 1980 strike, the AHA was "slaughtered" in the press, as one politician put it (Embury).

The adverse press received by the AHA in that strike was more likely to have been due to the superior campaign fought by the nurses than to any mistakes made by AHA spokesmen. (There had been one allegation that one AHA spokesman had referred to nurses as "angels

of mercenary" (Rheault)). It was generally conceded that both Donahue and Renouf were highly skilled in handling the media (Grothen; Rheault; Heise), and neither had been afraid to lambaste either the AHA or the government at opportune moments ("The AHA is a bunch of fools" Donahue was reported to have declared in a television interview (Mearns)). The AHA was the target of attack by individual nurses and often appeared as the villain on their picket signs, while the local employer was seldom if ever reviled. One nurse explained that it was the AHA that was blocking their goals, not the local management, some of whom had been quite proud of the stand the nurses were taking (Dancause).

In every strike the union made a concerted effort to keep its grievances in the public eye not only on the picket lines, but in demonstrations, talk-back shows, letters to newspapers, and telephone calls to elected politicians. Newspapers cooperated by running feature articles exposing certain working conditions, some in sensational detail (See for example, McLean, 1980). Most informants agreed that public opinion generally favoured the nurses in the first and second strikes but that it was more or less evenly distributed between the parties in the third one. The AHA was thought to have stated its case well in the 1982 strike (Embury), but there were signs of growing media impatience with the collective bargaining relationship: "This time, if nurses expect support, they are out of touch with the mood of the city. The public is tired of the repetitiveness of strikes and angry at what seems like constant union, management intransigence" (Calgary Herald, February 16, 1982).

Managing the media as a political resource served other functions besides building images. It provided an opportunity to continue the bargaining on another level, exposing the sorts of thrust and parry that usually go on behind closed doors. In so doing, a party could send messages not only to its own members, but to the opponent's membership, to government and to other influential groups. Both parties sought to increase their credibility through management of the media, but neither party seemed to have the same kind of lobbying success with the government or with the medical profession.

Sustaining economic sanctions. The term economic sanctions, otherwise known as strikes and lockouts, was probably a misnomer in the case of these strikes. Most likely the individual nurse incurred the greatest economic hardship as a result of the strike. The cost to the hospitals, however, tended to be in human rather than economic terms. Some hospitals even managed to reduce their anticipated deficits as a direct outcome of the 1982 strike (Lamb). No evidence was found to suggest that either party systematically calculated the economic costs and benefits of striking or of taking a strike in the manner generally inferred by theories of strike behaviour. Moreover, neither party was financially prepared for the enormous additional expense associated with the Public Arbitration Tribunal following the third strike, each incurring a budget overrun in excess of \$200,000 (Renouf; Heise).

The conflicts that arose between the parties in these disputes were the outcome of deep convictions about the righteousness of positions taken. The conflicts simmered throughout a series of

mediation and conciliation procedures in every dispute, generating a determination to fight out the struggle until somebody either won or lost, irrespective of potential costs and risks, human or otherwise. The parties both publicly declared that they did not want the government to intervene, and the AHA sent at least one formal request to the Minister of Labour to this effect (Letter from F. M. Pals, March 9, 1982). The Ministers in charge of Labour and of Hospitals and Medical Care made a practice of declaring publicly that they had no intention of intervening in the disputes, later reversing their positions.

Complex monitoring systems were set up by both the political and bureaucratic arms of government during the strikes and similar systems were established by the UNA, the AHA, and the organized medical profession. Officials in the Department of Hospitals and Medical Care maintained records of such things as the operational status of all hospitals; the availability of beds; critical incidents; the state of staffing in hospitals; the effectiveness of picket lines and the number of nurses returning to work (Lamb). The College of Physicians and Surgeons monitored the medical situation through a network of chiefs of hospital medical staff, and kept in daily communication with the Deputy Minister of Hospitals and Medical Care (le Riche).

It was the advice of the medical profession that played a major role in the political decisions to end the strikes. In 1977, it had been a Cabinet decision to declare a public emergency, as the Legislature was not in session at the time. Formal pleas had come from

Lethbridge physicians to end the strike and the College of Physicians and Surgeons had been preparing a similar request despite evidence that hospitals were coping well ("Strike:" 1977, p. 18). In 1980, the threat of strikes in 81 hospitals led to pressure on the government from the medical profession and from hospital boards themselves, particularly those in the Edmonton region (Embury). News that hospitals had asked for the government to intervene prompted the union negotiator to say that it was "conclusive evidence that the A.H.A. never intended to bargain in good faith" ("Ten day strike wins 38% raise," 1980, p. 1). In 1982, the decision to intervene was made by the Conservative Party Caucus on whom constituency pressures had been building during the three week strike, and a significant factor in the decision had been strong evidence of the failure of the parties to bargain in good faith (Embury).

To most observers in the 1982 strike, it seemed that the government was prepared to let the parties fight out their battle to the bitter end. After ten days, nurses had begun to return to work and hospitals had gradually opened up their inpatient units. However, as the strike wore on, the government consulted the College of Physicians and Surgeons and secured "incontrovertible evidence" of the seriousness of the public's unmet needs for medical care (le Riche). Hospital spokesmen, however, were satisfied that the hospitals remaining in service were managing well, some with augmented medical and nursing staff from neighbouring institutions affected by the strike. Nevertheless, physicians were in the best position to assess the full extent of morbidity among patients waiting at home to enter

the hospital system. It was no doubt difficult for physicians to justify further delay in the treatment of such cases as children requiring cardiac surgery or of people presenting signs and symptoms of serious disease. In addition, the incomes of many physicians were significantly dependent on the continuing operation of hospitals--a factor that could reasonably be expected to galvanize them into political action (Harrison).

The Alberta Medical Association, as the negotiating body for physicians, had no interest in taking a publicly partisan position although privately many physicians supported nurses, particularly in the first and second strikes. Physicians were themselves in disagreement with the government over medical fees as well as the question of their right to bill patients in excess of negotiated rates for medical care ("The doctors in revolt," 1980, p. 24). Not surprisingly, the position of both the College of Physicians and Surgeons and the Alberta Medical Association was that nurses and hospital employees should be designated as essential workers and denied the right to strike (le Riche; Milne, 1986).

Reflecting on the powerlessness of the AHA to prevent government intervention in its labour disputes, strategic informants acknowledged the close political ties of trustees to the provincial government. Nearly two thirds of hospital trustees were themselves local politicians with affinity for the ruling Conservative Party which had been in power since 1972. Not only were hospitals almost totally dependent on the government for funding, but the AHA through its trustees was irrevocably tied to public fiscal policy through party

allegiances (Pals). History revealed the AHA to have been a conservative organization in its dealings with government, although some hospital boards had occasionally chosen to go beyond provincial budget guidelines (Ross).

Prospective funding arrangements for hospitals required that budgets be submitted to the government several months before the beginning of the next fiscal year. Salaries and fringe benefits were accordingly estimated on the basis of prevailing government guidelines, and were incorporated into budgets long before collective bargaining had been concluded. With protracted negotiations and demands that exceeded the guidelines in every dispute, the question of whether the government would be prepared to commit the necessary funds in order for a settlement to be made became a critical problem for the AHA. It was evident that the AHA was more concerned about remaining within its own bargaining limits in these disputes than it was about exceeding the government guidelines. Hospital boards wanted firm guarantees of contingency funding before they would agree to alter their position at the bargaining table in spite of public assurances by politicians that funding would be made available. For example, the Minister of Hospitals and Medical Care said in the Legislature in response to a question on funding from the Opposition:

I think I have answered that question on earlier occasions, indicating that of course that financial commitment in past years has always flowed, whether [the settlement] was reached voluntarily or imposed by binding arbitration, as it was in 1977. The dollars have always been there. [In the event that hospital] boards haven't been able to meet those commitments and have run deficits, those deficits have been met. (Russell, 1980, p. 528)

In the absence of firm guarantees from the government, the AHA was

for all practical and philosophical purposes incapable of departing from its predetermined course without incurring the wrath of its membership. As an agent of the hospitals its mandate was to reach a fair and reasonable settlement that all of them could live with. Control over rising costs in hospitals had been a problem of some magnitude for almost two decades, and the largest single item of hospital budgets was labour compensation. Compared with other costs such as drugs and technology, labour costs were much more amenable to control through the process of collective bargaining. Also, extraordinary concessions to the largest group of workers would necessarily influence levels of compensation throughout the hospital workforce. It would seem that the ability to pay as determined by fiscal guidelines and prospective budgeting arrangements served as sufficient practical as well as moral justification for employers to hold the line at the bargaining table.

Summary

Organizational resources and constraints were identified as having contributed in different ways to the bargaining power of the parties. It was suggested, for example, that the structure of leadership in the union and the authority vested in the leaders to bargain were major political resources which enabled the union to pursue its goals with considerable success. On the other hand, the structure of leadership in the employers' association and the circumscribed authority of its negotiators proved to be dysfunctional under conditions of extreme stress and were therefore viewed as potential constraints to bargaining power. In summary, the following can be stated:

1. Sources of power derived from within union membership included: occupational homogeneity; performance of a strategic role in the technical core of hospitals; and limited substitutes in the labour market during strikes.
2. Sources of union intraorganizational power included: strong leaders and stable leadership succession; membership commitment to demands through a system of multiple repetitive ratification; information and communication control; reward and sanction capability.
3. Management of the media as a resource produced favourable public opinion for the union during the first two strikes.
4. Management of the media as a resource produced less favourable public opinion for the union in the third strike.
5. Potential bargaining constraints for the employers' association included: autonomy and diversity of institutional membership; diffuse and changing leadership; multiple, hierarchical decision-making structures; political allegiances of trustees to government; and incompatible organizational goals.
6. Public policy on wages and prospective budgeting procedures constituted major sources of power for the employers' association in resisting union demands.
7. Neither the union nor the employers' association possessed sufficient influence with external coalitions to prevent premature termination of their economic sanctions.
8. Despite prior public declarations to the contrary, the Alberta government intervened in each dispute. The potential for

government intervention in hospital labour disputes represented a source of uncertainty for the protagonists and a constraint to bargaining.

The major themes generated from the theoretical sampling have been presented in this chapter. The data were derived from a systematic review of institutional records of several organizations including union and management associations; from all public documents arising out of dispute resolution procedures; from Alberta Hansard and various newspapers; and from interviews with strategic informants. The following chapter contains a synthesis of much of the foregoing evidence and a discussion of causal factors associated with each of the strikes.

CHAPTER IX

Causes of the Strikes

In this chapter, the question which originally inspired the study is addressed: "Why did the nurses' strikes occur?" or stated another way: "What were the causes of the strikes?" All of the people interviewed were invited to respond to this question and without exception, they pondered it at some length, many agreeing that it was a difficult question to answer succinctly. Some interesting theories were advanced and the majority of explanations centred on the union and its leaders as primary causes. There were no clear indictments of the Alberta Hospital Association (AHA) as a leading cause of the strikes, and very few people cited bad faith bargaining as a factor. Nurses tended to explain the strikes in terms of their bargaining objectives and the complaints that prompted them to turn to the union in search of redress.

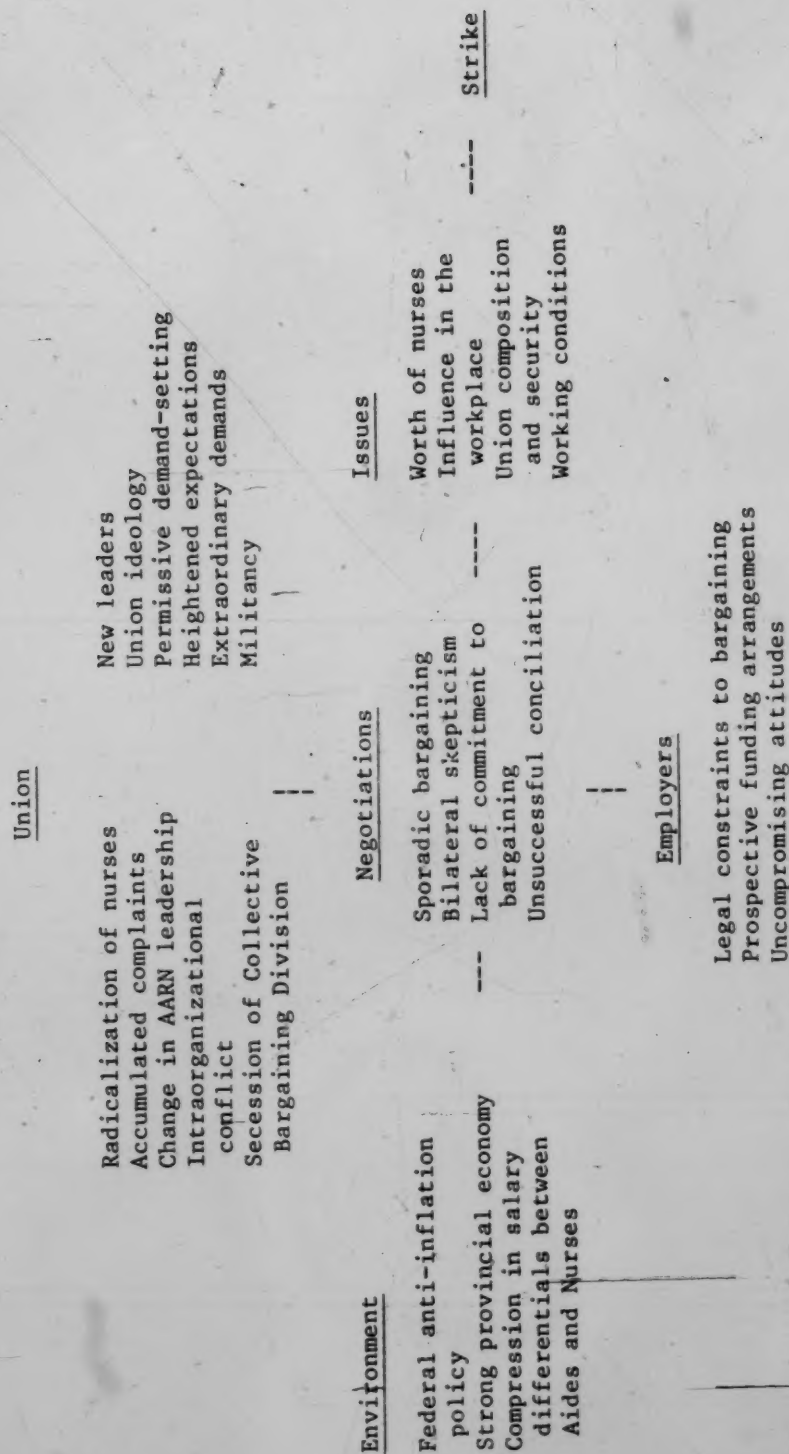
The evidence presented in the previous chapter confirms the findings of the literature review that strikes are complex social phenomena and that there may be multiple causes of impasses at the bargaining table. This being the case, the strikes are discussed one at a time in this chapter to ensure an orderly and comprehensive explanation; however, the analysis revealed that factors found to have contributed to the strikes could be presented within a common framework. Although the strikes were three discrete events having unique features, there were circumstances that were true of all three. For example, throughout the six year period, public policies governing wage increases were in effect, but the union's wage demands

significantly exceeded both the guidelines and the employers' ability to pay without additional public funding. In every dispute certain contentious issues dominated the negotiations and reappeared at each successive round of collective bargaining. The parties reported recurrent technical problems in the conduct of their bargaining, and dispute resolution procedures were exhausted in every case. Causal factors whether common or unique were identified and organized within a framework of five general concepts, namely: environment; union; employers; negotiations; and issues. This conceptual framework is presented in Figure 6 together with the causal factors associated with the first strike of 1977.

The First Strike

It will be seen from Figure 6 that there were several predisposing factors in the first dispute. The union began as a membership service of the Alberta Association of Registered Nurses (AARN), and for twelve years prior to the strike the AARN served as the bargaining agent for nurses under the labour legislation. A change in the leadership of the AARN led ultimately to some significant changes in the Association's collective bargaining division, and revealed the existence of a renewed interest in unionism among nurses. Largely as a result of a union activist, Bob Donahue, who had conducted what was termed a radicalization program from 1973-1976, a critical mass of nurses in strategic local staff nurse divisions had been persuaded that unionism held much potential for dealing with long standing socioeconomic and job-related problems. Donahue was subsequently

Figure 6. Causal factors in the first strike: 1977



promoted to the top administrative job in the collective bargaining division of the AARN in November 1976, and although he was not a nurse the appointment was thought at the time to have been an obvious and appropriate one (Chapman)¹. The appointment was followed by a period of unprecedented turmoil and intraorganizational conflict. Under the new leader, who used a carefully orchestrated strategy of confrontation, a policy decision by the AARN leaders was secured, permitting the collective bargaining division to secede without jeopardizing any of the existing collective agreements. An independent trade union, the United Nurses of Alberta (UNA) was established in June, 1977. The separation of professional and collective bargaining powers in this way was consistent with a trend in Canadian nursing begun in 1973 in Saskatchewan.

The energy generated within the union during the conflict with the AARN was rapidly channelled into the conflict developing at the collective bargaining table with the Alberta Hospital Association. As one nurse said, all that "hype" had to be sustained if there was to be a favourable strike vote (Bennett). The excitement was sustained mainly by Donahue who possessed exceptional organization and communication skills, and who was supported by two well chosen employment relations officers, a small group of elected representatives, and a new chairman of the union's negotiating committee, later to be the union's first President.

¹Strategic informants are cited in this chapter by last name only. An alphabetical list of strategic informants giving titles and dates of interviews can be found in Appendix E.

One of the objective outcomes of the radicalization process was an unusually large package of negotiating demands. Union ideology and a strong commitment to the democratic process had led to an outpouring of needs and wants of the nurses and had provided opportunities for the expression of past complaints and employment problems. These issues had been accumulating over the previous two or three years and had stemmed from three sources of discontent. First, there were many concerns about the staffing of hospitals and about the quality of care being given to patients. Nurses were feeling vulnerable both to litigation and to professional discipline, and were expressing many concerns about the possibility of mistakes or malpractice under the stress of inordinate workloads. Second, there was a sense of injustice with respect to compensation inequities and, in particular, to the fact that the gap between the salaries of nursing aides and Registered Nurses had been significantly narrowed. Third, nurses said they were dissatisfied with the type of representation developed under the auspices of the AARN both in collective bargaining and in grievance handling. They also felt that they had been too acquiescent in abiding by the Anti-Inflation Board guidelines introduced by the federal government in 1975, and that the good nature of their former negotiator had been exploited by the AHA.

The leaders of the newly constituted union took immediate steps to address all of these sources of dissatisfaction. The number of contract grievances in hospitals began to go up, and a year or so later it was estimated that 80 percent of all grievances handled by the AHA were being generated by the United Nurses of Alberta

(Pedden). A systematic and more permissive demand-setting procedure within the union resulted in a salary demand that was six times in excess of the limit allowed under the federal wage controls. Thus, there were heightened expectations of the negotiating process among the membership and a deep commitment to the union effort, especially among the leaders of the larger union locals.

High membership demands and the reality of public policy aimed at reducing inflation placed the union negotiator in a predicament. His own survival as a leader depended on his ability to fulfil promises made, to say little about the survival of the union itself as a fledgling organization. The pending strike now began to resemble one of union recognition in that the bargaining agent had to be reconstituted and all bargaining units recertified as chartered locals of the United Nurses of Alberta.

The role of the AHA in this dispute can best be described as passive and defensive. There were legal constraints to bargaining because wage increases were limited to six percent irrespective of any sympathy employers might have felt for the union's position. The AHA secretariat had followed the turmoil within the AARN with much interest and recognized the precarious state of the new union organization. It therefore saw no reason to promote union security by conceding to the demand for automatic payroll deduction of union dues. Nor did it intend to yield any of its control of the workplace or its management rights to institutional committees on nursing.

At the time of the strike there were 44 proposals outstanding. At the Arbitration hearings the union dropped 15 proposals and

presented the remaining 29 for resolution (Brief of the Collective Bargaining Program: 1977). These 29 issues could all be subsumed under four general categories: the worth of nurses; influence in the workplace; union composition and security; and working conditions. Salaries and the demand for a committee on nursing were the major stumbling blocks for the employers. For nurses, however, the proposal that would give them more influence in the workplace legitimized their struggle, persuading them that with such mechanisms they would be able to fulfil their professional responsibility for improving patient care.

Negotiations began in January 1977 and after three meetings, were suspended while the union became preoccupied with its internal affairs. When negotiations resumed with the assistance of a conciliator, there was little, if any, commitment to bargaining on either side of the table and little mutual trust. The change in attitudes of the nurses convinced the AHA negotiating team that the union leaders were not representative of the rank and file nurses and, on the other hand, the nurses were offended by the ridicule and uncompromising attitudes of the management team. The so-called bilateral skepticism towards negotiations was generalized to the conciliation commissioner whose report the union ultimately rejected.

Several of the management informants observed that it was madness for the union to strike under the circumstances, which raises the question of why nurses agreed to launch their first strike at that time and in the face of such unlikely odds of success. The timing of the strike was critical for establishing the credibility of

the new leaders as well as the efficacy of the new bargaining agent, but there were two additional considerations. Although not all nurses were wholehearted in their support of Donahue or even of the UNA, enough of the local leaders were persuaded that a showdown with the AHA was necessary to achieve their goals. Donahue concentrated his mobilization efforts only on those large union locals with effective leaders who appeared to be supporting him, and it was on this basis that he selected the first seven hospitals to strike. For example, it was at the Edmonton General Hospital (one of the seven) where the executive officers of the union local had been suddenly replaced by a new and more militant group of nurses. The fever of unionism was high and the members had been convinced that the logic of their argument was unassailable--they had been unjustly treated in the past and so there could be no question of not winning (Bennett). "We had been held back for so many years and now we found we could speak freely at union meetings and say what we wanted. It was as if the cork came out of the champagne bottle," Gurty Chinell told the investigator.

The second important consideration was the extent of the leadership control Donahue was able to exert on the membership. According to him, the reason why nurses went on strike in 1977 was because he told them that they had no choice and that they had to strike (Donahue). This rather singular claim was substantiated later by other informants (Bennett; Dancause) and was indicative of Donahue's risk taking propensity and his power within the union at the time. Several AHA participants agreed that one of the principal causes of

the strike was Donahue, and suggested that as a layman it was necessary for him to prove that he did not have to be a nurse to run the union (Rheault; Mrazek). According to Donahue, the strike was a struggle for 'personhood' and a statement about the nursing profession and the working conditions of nurses (Donahue). His official explanation appeared in the first edition of the union's newspaper:

Nurses took strike action as a united group to serve notice on the employers that their "divine right" to rule was over and to call a halt to further devaluation of the services of a nurse in the community. (UNA News Bulletin, 1977, n.p.)

In summary, the following statements can be made:

1. The first strike occurred at a time of unprecedented activity and growth in the provincial economy of Alberta.
2. The establishment of an independent trade union for nurses in 1977 signalled a landmark in the history of the nursing profession in Alberta and a new era of self-determination by nurses in socioeconomic affairs.
3. A primary cause of the strike was a union activist promoted to the top executive position in the union who planned, executed, and controlled a strike in seven major active treatment hospitals in the province.
4. Nurses were sufficiently convinced of the validity of their accumulated complaints; of inequities in their compensation; and of the legitimacy of their demands to respond to the directive of the union leader to withdraw their services in seven major hospitals.
5. The employers' association was powerless to prevent an impasse in negotiations due to the limits of federal anti-inflation

legislation, provincial funding constraints, and extraordinary union demands that were supported by a strong commitment among nurses to their bargaining objectives.

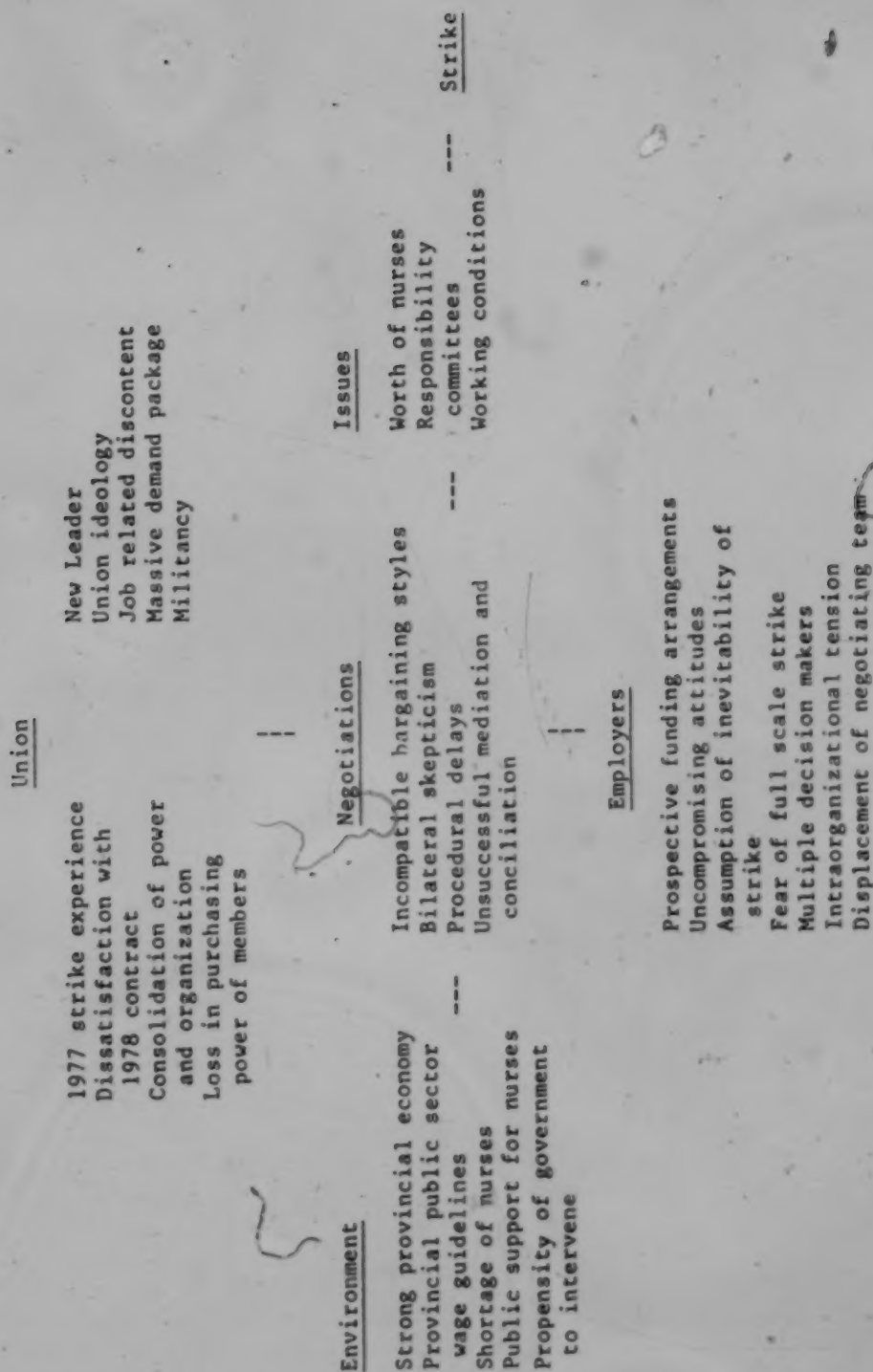
6. Sporadic negotiations, bilateral skepticism, lack of commitment to bargaining on the part of both parties, and failure of conciliation procedures led ultimately to the strike.

The Second Strike

The second strike differed from the other two primarily in the number of hospitals involved. The causes are best understood in light of the immense threat that it posed for 81 hospital boards. The seven hospitals involved in the first strike were all located in urban areas where, for the most part, other hospitals remained in operation. This strike, however, threatened to reach out into isolated rural areas where alternative hospital services were nonexistent. Regional strike contingency committees were set up to oversee and coordinate the pooling of human and material resources. Plans were made to refer patients with critical care needs to the provincially owned tertiary care centres, and the early discharge of patients was promoted. Elective admissions to hospitals were cancelled. Hospital boards had very grave doubts that they could cope with such an enormous reduction in hospital services without untoward incident--a fear that was shared by government leaders. The alternative was apparently equally abhorrent, namely to concede to union demands.

The factors which contributed to this strike are summarized in Figure 7. As before, there were predisposing union factors, the most

Figure 7. Causal factors in the second strike: 1980



important of which was the experience and confidence gained by nurses during the first strike. According to Donahue, the 1977 strike was a supremely radicalizing experience for nurses and the union might have collapsed if that experience had been denied them (Donahue). In any event, the strike had served as a symbol of what concerted effort could achieve, in view of the fact that two levels of government had been forced to compromise their anti-inflation policies. Symbols of success, however, do not help to pay mortgages or food bills and, in retrospect, union leaders admitted that not much had been gained by the first strike (Ethier).

The disappointing outcomes of the 1977 dispute and the unexceptional economic gains in the collective agreement of 1978 were indications to the union that the purchasing power of nurses had declined and that there was a need for some significant catching up. In the two and a half year interim since the 1977 strike, the union had increased in size, power, and effectiveness of operations, and it had established and built up a contingency strike fund. Power and control within the union had been transferred to elected representatives of the Executive Board and a new Executive Director had been hired. This was altogether a much more powerful union entering negotiations with the AHA in 1979 than had been the case three years before.

The union's demand-setting process generated an unprecedented package of bargaining objectives in which there was scarcely a clause in the collective agreement that the leaders of the union did not want to change. Salary demands were for increases of 33.3 percent in

a one-year contract and, together with other economic demands, they constituted a potential increase in the total cost to employers of approximately 76 percent over the existing contract. Moreover, there were demands in which the intent was (a) to improve working conditions, (b) to predict working hours and to promote desirable life styles, (c) to institute a system for influencing decisions in the workplace, (d) to secure portability of benefits between hospitals, and (e) to gain one paid educational day per nurse, per month (approximately 8400 paid days). In addition, there were demands that in effect, would purge the agreement of the masculine pronoun and all wording that permitted employer discretion.

These demands had widespread support from the grass roots of the union. When Renouf joined the union as the new Executive Director in 1979, he said that he was amazed by the militancy of the nurses, and that he knew there would have to be a strike. When it happened, he and his negotiating team were swept along on a wave of militance "much like a surfer on a surf board" (Renouf). This was a protest about working conditions, low salaries, and shortages of nurses which were expected to become much worse if the Alberta government proceeded with its ambitious hospital construction program.

The issues that brought the parties to an impasse were again economic and substantive including the question of responsibility committees, working conditions, and work schedules to promote normal lifestyles for nurses. The demand for institutional responsibility committees met with great resistance from the AHA and arguments against it were based on the principle of management rights and the

legal obligation of member institutions to operate their hospitals. Hospital boards were adamant that they did not want such a clause in the collective agreement, nor would they live with such a provision (e.g. Letter from L.B. Hill to J. Henderson, AHA Executive Director, March 27, 1980). Professional responsibility committees were now commonplace in nurses' collective agreements in Ontario (Lewis, 1976) and elsewhere, and the union had a strong mandate to insist that there would be no settlement without a concession on this demand. Professional responsibility committees were considered to be essential if nurses were to have any impact at all on the problems they were confronting in the workplace.

There were some unique problems for the AHA in the second dispute and these were related to the achievement of internal consensus. Almost as important as relationships between the two parties in negotiations is the process of "intraorganizational bargaining". Intraorganizational bargaining refers to the activities associated with achieving agreement in the expectations of the negotiator with those of the people or groups he is representing (Walton & McKersie, 1965). There were tensions within and between the various constituents of the AHA having the power to influence negotiations. There were hardline attitudes among people on the negotiating team, within the AHA secretariat, and among the members of the Employee Relations Committee (ERC), but at the same time, some of the more influential hospital boards were bringing pressure to bear on the AHA to be more flexible at the bargaining table. The negotiating team resented the tight rein kept on it by the ERC, and when the message was sent from

the ERC to the negotiating team to make a salary offer of six percent to the union, the negotiator refused to carry out the directive. He considered the amount to be so miserly and insulting as to have been ridiculed by the union, with negative consequences for relationships at the negotiating table (Owen).

The AHA negotiating team apparently made an assumption early on in the collective bargaining process that a strike was inevitable. The massive demands, the union demonstrations of solidarity, the evidence of public support, and the restrictive provincial wage guidelines seemed to indicate that there was very little the bargaining team could do to avert the strike. Although there would have been no legal penalties this time for exceeding the 7.5 - 9 percent provincial wage guidelines, hospital revenues had already been predetermined through the process of prospective budgeting, and hospital boards were unwilling to yield to the demands of the union to the extent of incurring operating deficits.

The parties were at odds over the role played by the government in collective bargaining. The position of the union was that it was dishonest of the AHA to presume that it could negotiate independently of the provincial government which funded the hospitals. The AHA insisted that it had complete authority and autonomy in collective bargaining with hospital employee unions. However, as the negotiations began to falter, so the government was drawn into the dispute. Two attempts to promote agreement through conciliation procedures failed. The union accused the new Minister of Labour of using the tactics of delay when he failed to reveal the results of one concili-

ation procedure and gave two time extensions to another. These delays served to accelerate the political activities of nurses in bringing their complaints into the public domain, giving them time to make systematic and detailed strike preparations (e.g., plastic covered picket signs to avoid the devastation caused by rain in 1977).

The second strike was the only dispute to be settled without recourse to interest arbitration. A decision was made by the government to refer the dispute to arbitration but nurses defied the Order-in-Council to return to work, which necessitated the direct involvement of the Minister of Labour and various government officials. It was the opinion of the AHA spokesman that by attempting to put an end to the strike after only three days, the Minister had played right into the hands of the union (Rheault). The divisiveness within the AHA and the "behind the scenes wrangling" did not go unnoticed by the union negotiator, and as one member of the AHA negotiating team grimly noted, all the union had to do was to wait until management came up with the right package (Mellors).

In summary:

1. The second strike was preceded by a period of two and a half years in which the United Nurses of Alberta consolidated its power and internal structures; secured a guaranteed source of income; set up a strike contingency fund; transferred power and control to elected representatives; and appointed a new Executive Director.
2. A complex demand-setting procedure generated a massive package

of bargaining objectives, giving the UNA negotiating team a strong mandate and unequivocal power at the bargaining table. Union ideology and solidarity gave rise to a militant commitment at the grass roots of the union to publicly declared goals.

3. The rationale for the union's demands included: loss in purchasing power due to disappointing settlements in the two previous rounds of bargaining; a shortage of nurses and associated complaints; an expressed need to address work related dissatisfactions on a formal basis with employers; and the determination to influence decisions made in the workplace that affected the quality of care to patients.
4. Bargaining constraints for the employers included provincial public sector wage guidelines; inability to pay the potential settlement due to prospective budgeting arrangements; uncompromising attitudes of key decision-makers; and an assumption by the negotiating team that the strike was inevitable.
5. Negotiations were characterized by incompatible bargaining styles, bilateral skepticism, procedural delays, and the failure of two attempts to conciliate the dispute.
6. Under the extreme stress of a threat to strike in 81 hospitals and public support for the union, intraorganizational tensions developed among constituent groups of the employers' association, undermining confidence in the negotiating team, and leading to a dislocation of the normal decision-making process.
7. An impasse in negotiations was reached over issues related to the worth of nurses' services; responsibility committees; and

working conditions.

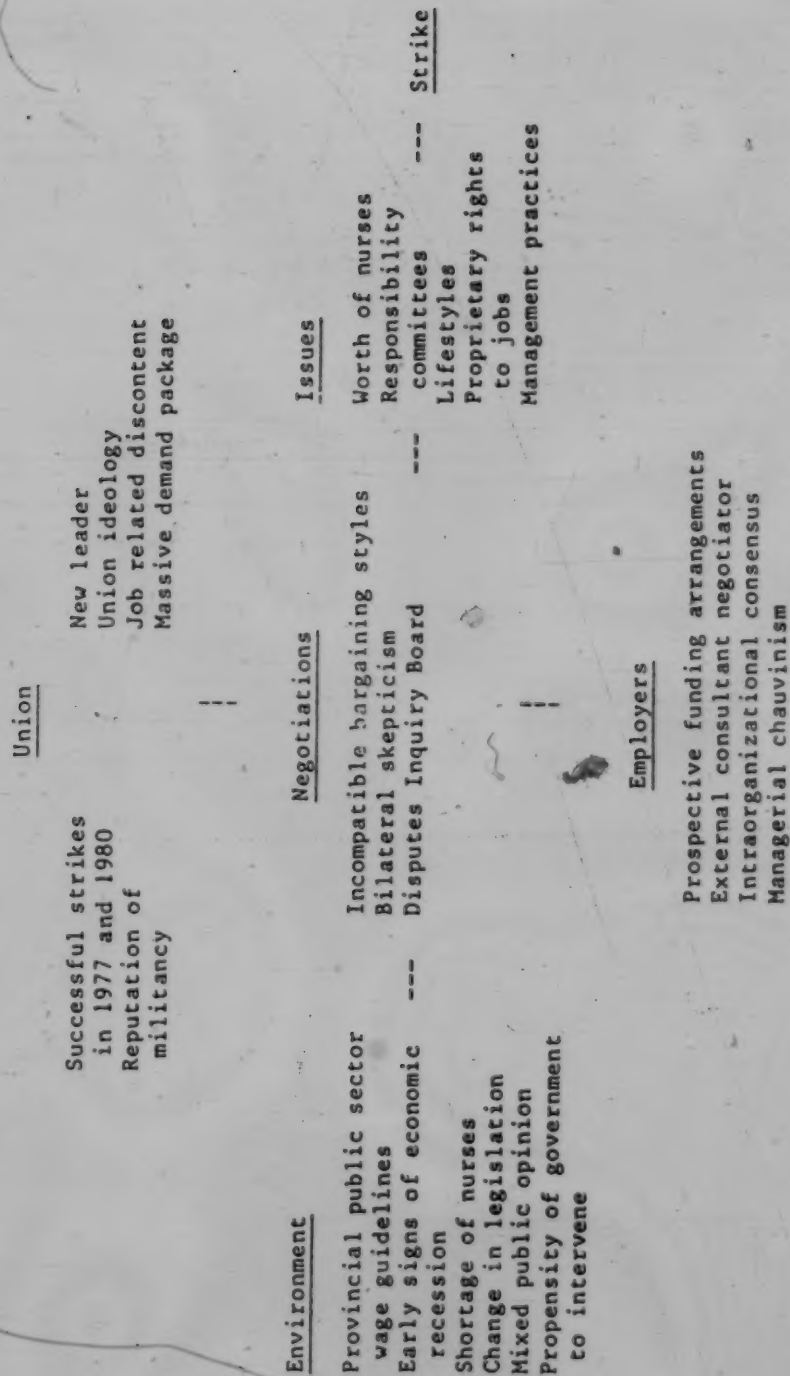
8. The propensity of the Alberta government to intervene as demonstrated in the dispute of 1977, was again exemplified by the personal involvement of the Minister of Labour in the negotiations, and by the government's Order-in-Council to end the strike, thereby relieving the protagonists of the responsibility for serious collective bargaining.

The Third Strike

Of the three strikes, the last was said by participants to be the most difficult to explain. On the whole there seemed to be less public support for the union, and nurses themselves were less enthusiastic in their endorsement of the strike, as was revealed in the less favourable strike vote compared to earlier disputes. Other factors included the two contradictory Disputes Inquiry Board votes, and a greater willingness on the part of nurses to cross their picket lines. Operating room nurses in particular tended to ignore the call to strike, because as the union President explained, these nurses had good working hours and fewer reasons for supporting the lifestyle demands of their colleagues that emerged as contentious issues in this dispute (Ethier). Nurses in rural areas were less willing to risk the public disapprobation experienced in 1980, saying that their whole communities had been against them (Chinell). Also, nurses picketing in urban areas were subjected to much more verbal abuse than in previous years.

In Figure 8 the factors that contributed to the third strike are presented. It will be seen that there were many similarities in the

Figure 8. Causal factors in the third strike: 1982



causal factors of the second and third strikes, but there were also some important differences. Perhaps the most significant difference was the early indication of a downturn in the provincial economy. The shortage of nurses during 1980 had persisted, but this dispute extended into the spring and summer of 1982 at which time job vacancies for nurses had declined and the provincial unemployment rate had begun to rise.

Once again there were predisposing union factors. By this time the union had earned a reputation as one of the most, if not the most, militant union in the public sector of the province. It had achieved a qualified success with the first strike but the second strike had been a phenomenal success. Thus, to union leaders it was probably safe to try the same tactics again since member support was clearly evident. It was the conclusion of several management people that this strike could be explained in terms of reinforcement theory, for example, that the union kept repeating the tactics that had worked for it in the past (Macgregor; Barrass; Connolly). Union leaders argued, however, that they had exhausted every avenue of due process in representing their members, and that as these means had failed there was no alternative but to strike.

As in both of the previous strikes, the union entered negotiations with a new leader. The newly elected President appeared to be reaffirming union ideology and taking aggressive, sometimes contemptuous positions vis-à-vis the AHA and the government. In the interim between the second and third strikes, the AHA had released its Manpower Study (1980) providing some limited evidence of dissatisfac-

tion among nurses, in particular with managerial policies and working conditions. In their verbal attacks on management practices in Alberta hospitals, union leaders argued that the Manpower Study substantiated their position that there was need for reform in hospitals. "Since we were all saying the same thing we ought to have had no problem coming to an agreement," the union President observed (Ethier).

The issues that polarized the parties in this dispute were much more complex than in previous years. Although the union argued that money was not a major concern in this round of negotiations, there were substantial economic demands that could not be settled apparently without a strike. For example, it was a strike issue for the AHA to concede to the demand that the salary differential between graduate and registered nurses be abandoned. The worth of a nurse's services remained an important theme in the arguments of the union and in its subsequent position at the Public Arbitration Proceedings. The issue of professional responsibility was again on the negotiating table, and although institutional committees had been formed and were being used, union leaders said these committees were powerless and in need of "more teeth." The general strategy of the union in pursuing its bargaining objectives seemed to be one designed to shock the employers with outright attacks on management practices and the revelation of unsafe care to patients throughout the province. Predictably, employers were outraged by these allegations and became defensive and less inclined than ever to consider the underlying problems faced by some of the nurses. The acrimony in negotiations

centred around professional responsibility, management practices and management rights, and stimulated attitudes within the AHA that were labelled earlier as managerial chauvinism.

Other issues over which there seemed to be no middle ground were what the AHA negotiator referred to as proprietary rights of a nurse to her job (Barrass). Examples of demands that revealed this goal included: control over where and when a nurse would work; control over what tasks a nurse would or would not undertake; guarantees of returning to the same position following approved leaves of absence; and provisions for restricting layoffs. More contentious still were demands that were labelled lifestyle issues and included: posting of work schedules 12 months in advance; limiting rotations to two shifts only; day shift to be worked two fifths of the time; every other weekend off; and restrictions to the scheduling of part-time and casual nurses to allow them to predict both their incomes and their abilities to fulfil social obligations.

These and other demands all indicated a determination to increase the power and control of nurses over the context within which nurses practised their discipline. They wanted the right to refuse employer directives to work alone on a nursing unit or to work in unfamiliar units. By strengthening the responsibility committees through recourse to external adjudication, the union proposed to tackle the problems of workload and quality of patient care by a continuing process of confrontation or the threat of confrontation. Union leaders explained to the Public Arbitration Tribunal set up to resolve the dispute that they had rejected the idea of cooperative

problem solving with employers such as discussing appropriate nurse/patient ratios (Arbitration Tribunal Proceedings, 1982, p. 33). Rather, they preferred to challenge the operational decisions of managers through formal dispute resolution mechanisms because, as the President said: "We are not after participative management but we do want management to manage" (Ethier).

One consequence of the intraorganizational problems faced by the AHA in the 1980 dispute was that it had become determined to enter negotiations next time as a united front. It had completed an inquiry into its employee relations services and approved a statement of philosophy for collective bargaining. It had secured a commitment for centralized ratification of any memorandum of agreement by the Board of Directors, improved its internal communications, and hired an experienced and respected outside consultant negotiator. Moreover, regional arrangements for strike contingencies were by then well established and proved to be increasingly efficient. In fact, the AHA had become a more formidable opponent than in the previous disputes.

Negotiations were again characterized by incompatibility in bargaining styles and failure of the parties to take each other's position seriously. This time there had been a real effort on the part of the AHA to start off on a better footing and to avoid bargaining through the media. It therefore sought a pact with the UNA not to use the media, but the union left the first meeting and immediately issued a press release (Heise). The strong resistance of the employers forced the union to take definitive action, despite the

fact that the AHA made its salary offer earlier than in previous years.

As a result of changes in the labour legislation, mandatory conciliation was no longer required, which meant that a strike was possible as soon as the existing collective agreement had expired. In November 1979, the AHA applied for the assistance of a mediator but the talks broke down a month later and a strike vote was held. The vote was in favour of strike but not overwhelmingly so. Under the amended labour statute, the Minister of Labour had the authority to call upon the assistance of a Disputes Inquiry Board (DIB), and if this was done before the commencement of a strike then the strike could be deferred. Imposing a DIB on the parties served as a means of buying time and perhaps of reducing tensions between the parties to the dispute.

Tension within the union was rarely dissipated by these interventions because procedural delays often became irritants for the rank and file nurses who wanted to know what was going on in negotiations (Chinell; Dancause). Some of the management personnel believed that the union exploited such road blocks to agreement in order to generate impatience among the members and to rally them to the cause. Thus, it was said to be politically expedient for the union negotiator to keep valued bargaining objectives unresolved in order to foster militancy at the grass roots. This theory would seem to explain the observation of AHA informants that the union seemed unwilling to settle certain issues, bringing them back repeatedly to the bargaining table (Mrazek; Connolly). It was also suggested that

launching a strike was a calculated risk for union leaders who expected government intervention in time to prevent disillusioned strikers from turning against them (Barrass). The AHA and the government seemed prepared to test this hypothesis by allowing the strike to continue for 23 days, or until approximately one third of the nurses had returned to work.

The impatience of the medical profession to restore full hospital services, the accumulating morbidity, and the increasing public pressure on the government led to the passage of what was regarded as a punitive piece of back-to-work legislation and the end of the strike. As in the 1977 dispute, government intervention was again responsible for what would most likely have been a collapse of the strike.

Disputes Inquiry Board. Some of the participants in the third dispute regarded the Disputes Inquiry Board (DIB) as one of the main causes of the strike. Union leaders said that it became the culminating factor that strengthened the nurses' resolve to strike. The union had opposed the Minister of Labour's decision to appoint the DIB on the grounds that it was an unwarranted and improper intrusion into the collective bargaining process (Moysa, 1981). Secondly, the lawyer selected to chair the Board, Eric Lefsrud, was considered by the union to have been incapable of dealing with sensitive labour relations problems (Renouf), and thirdly, the Minister was reported to have acted like a "tinpot dictator" in ordering a government sponsored vote on the DIB report (Moysa, 1982).

Nurses who voted in the government sponsored vote on the DIB

recommendations were generally in favour of accepting them. However, most of the nurses followed the advice of the union and boycotted the government sponsored vote; they overwhelmingly rejected the DIB recommendations in the union sponsored vote. The union charged that the needs of the membership had not been addressed in the recommendations and that much of the language of the report was offensive and had angered the nurses, leaving them with a feeling of betrayal (Renouf). The tone of the report was said to be didactic, paternalistic and uncomprehending of the work of nurses, and the recommendations of the chairman had disproportionately favoured the employers. Examples of the offensive passages were:

As I understand it, basically all nurses perform the same type of work. (DIB, 1982, p. 115)

I am of the opinion that the position taken by the Employer is correct, fair and equitable and in the proposed Collective Agreement I have adopted the position of the Employer in its entirety. (DIB, 1982, p. 20)

The Union has advanced several clauses similar in nature and each time, in my opinion, they represent a position which, if attained, would provide to the Union in-roads into the rights of an Employer to run its business The simple proposition in each of these areas is that, pursuant to the management rights clause, the Employer must at all times be armed with the unfettered right to operate its business. (DIB, 1982, p. 32)

I must point out that in its arguments before me the Union did not cite one case of dissatisfaction with the professional responsibility committee and I have no alternative but to presume from silence on that point that although the Union anticipates that there could be problems in the future, at least to this point the committee and the system thereunder is working properly I have absolutely no hesitation in recommending that there should be no changes or additions to the professional responsibility article. (DIB, 1982, pp. 49-50)

The Chairman of the DIB recommended a generous salary increase, which led the union to conclude that he had assumed he could buy off the

nurses by addressing their economic needs but not their concerns about the workplace. To have accepted the DIB report, according to the union negotiator, would have been to have set back the cause of nursing in Alberta by several years (Renouf).

The Board of Directors of the AHA did not like the DIB report any more than the union and was deeply concerned about the cost implications of the economic recommendations to the hospital industry. In its brief to the Public Arbitration Tribunal, the AHA explained why it had accepted the DIB report:

Despite the serious reservations the AHA held with regard to certain aspects of this report, the Association reluctantly gave its approval in a last ditch attempt to avoid a strike not because it considered that report to be a proper compromise but rather, as stated, to go that extra mile to avoid inflicting upon the hospital's [sic] patients the distressing trauma which would result from a strike. (AHA Submission: 1982, p. 5)

The parties returned to the bargaining table following the disparate results of the two votes on the DIB recommendations. The AHA took the position that the recommendations would form the basis of further negotiations: "but only insofar as exchanges could be made within the ambit of the report, which exchanges would be beneficial to both parties not solely to the Union's benefit" (AHA Submission, 1982, p. 6). The union, however, had earlier stated that it reserved the right to introduce any or all issues remaining in dispute in the event of third party intervention, and proceeded to revive some 60 former demands (AHA Press Release, February 24, 1982). Thus, the DIB became an issue itself, because when the parties met, there was a dispute over whether or not the DIB report represented the floor or the ceiling of the final settlement.

In summary:

1. The third strike was less clearly supported by the public, and less enthusiastically endorsed by union members.
2. Issues in dispute were economic and substantive, the most contentious being demands for: increasing control over decisions in the workplace; proprietary ownership of position; and work schedule changes having implications for the lifestyle of nurses.
3. Constructive efforts by employers to improve the collective bargaining climate were thwarted by the union's tactical allegations of unsafe and improper management practices.
4. Changes in labour legislation resulted in an earlier strike vote than in previous disputes and the appointment of a Disputes Inquiry Board.
5. The recommendations of the Disputes Inquiry Board were couched in rhetoric that angered the nurses and favoured the employers.
6. Further negotiations were complicated by a dispute over the role to be played by the Disputes Inquiry Board recommendations, leading directly to the final impasse.
7. The propensity of the government to intervene as established in earlier disputes was again demonstrated, despite evidence of a faltering strike, relieving the protagonists of the responsibility to strive for a collective agreement.

All of the findings from the theoretical sampling and analysis have now been presented. In the final chapter which follows, the various threads from the discussion to this point are drawn together, and conclusions are made.

CHAPTER X

Discussion and Conclusions --

In this final chapter the last of the three research objectives is addressed, namely, to develop the elements of a theory to explain the labour disputes of Alberta nurses. The search for causes in this study led to an examination of the context of labour relations in the Province of Alberta and of the history of the collective bargaining relationship between nurses and hospital employers. The literature in the field of collective bargaining indicated that these aspects of the labour relations system were likely to throw considerable light on why the strikes occurred. A thematic analysis of the three strikes by nurses was presented in Chapter 8, and a summary of causal factors relative to each individual strike appears in Chapter 9. An attempt is now made to pull those aspects of the study together and to draw some conclusions.

An Overview

The Roots of Protest

During the years in which the Alberta Association of Registered Nurses (AARN) was engaged in collective bargaining on behalf of its members it had to contend with two major difficulties. The first was the relative weakness of its bargaining power as long as nurses voluntarily rejected their right to strike. In the days of association-consultation between the AARN and the Alberta Hospital Association (AHA), employers were often perceived by nurses as paternalistic and unwilling to be reasonable on the question of salaries and terms and conditions of employment. The failure of a few hospital boards

to grant voluntary recognition to their staff nurse associations for the purpose of collective bargaining led nurses to press for the certification of these associations under the Alberta Labour Act. Employers were then obligated to enter negotiations with their nursing staff.

The AARN served as the bargaining agent for nurses under the Alberta Labour Act for a period of twelve years. Jointly with the AHA, they built up a strong centralized bargaining structure on behalf of their respective Associations, and these arrangements influenced the employment conditions of nurses right across the province. For seven years the parties operated under a procedural agreement which, in effect, provided for the relinquishment of strikes and lockouts in favour of conciliation for settling collective bargaining disputes. Following one serious dispute, nurses recognized the weakness of their bargaining position and abandoned the procedural agreement, and in 1973 they threatened to strike in two Edmonton hospitals. The outcome of these threats produced significant economic gains for nurses. In fact, union leaders later claimed that, relatively speaking, the salaries of nurses in 1975 had been "about right" (Brief of the Collective Bargaining Division: 1977). That was the year in which federal anti-inflation guidelines were introduced, and it was also the year in which the United Nations proclaimed International Women's Year. Societal values were clearly changing with respect to the place of women in the workforce, and so were the attitudes of nurses about themselves and the value of their services.

The second problem faced by the AARN was the question of functional autonomy of the collective bargaining program. The AARN membership comprised both management and staff nurses, and its policy-making body, the Provincial Council, was historically dominated by nurses holding senior executive positions in health care agencies and schools of nursing. Although the AARN had served as the nurses' bargaining agent, its leaders recognized that it might not survive a legal challenge should one be launched by the labour movement. It was the Saskatchewan nurses' professional association, however, that was ultimately challenged in this way, which led to renewed efforts by Alberta nurses to insulate their collective bargaining program from potential managerial influence. Total separation of the professional and collective bargaining divisions of the AARN was considered to be a future possibility in 1974 when the "purification" of the structure took place, but there was little interest in pursuing that option at the time.

The impetus for complete independence in socioeconomic affairs arose following a change in the leadership of the AARN's collective bargaining division. Social forces also played an important role in galvanizing nurses into seeking self-determination as a trade union. The Alberta economy was exceptionally strong in the mid-1970s, offering many alternative employment opportunities for nurses. Population changes were creating a need to expand health services which, in turn, were increasing the demand for nursing manpower. Shortages of nurses were having immediate implications for the quality of worklife of practising nurses in hospitals. The management of nursing ser-

vices under these conditions came under increasing criticism from the nurses themselves and their union leaders.

The union's Executive Director, Bob Donahue, together with a core group of local leaders who had been persuaded that the AARN had been too conservative in its representation of nurses in the past, sought total emancipation as a labour union. (These events were discussed in detail in Chapter 6). An ambitious plan for the expansion of employment relations services was developed which promised to deal effectively with the job-related complaints of nurses and led inevitably to conflict within the AARN over increased funding for the collective bargaining division. If, as claimed by Donahue, it was his intention to bring about a schism within the AARN, the question of funding was an excellent issue over which to have a disagreement because it effectively revealed the difficulty of providing for complete functional autonomy in the matter of socioeconomic affairs under one organizational constitution. The dispute over funding within the AARN served to rally the membership around the new leaders, and to prepare for the conflict developing with employers at the negotiating table.

The separation of the collective bargaining division of the AARN exemplifies the conflict in cultures that seems to be endemic to nursing. Melosh (1982) points out that the mainstream in nursing belongs to a work culture that has been nurtured in the apprenticeship traditions of hospital schools of nursing. The vast majority of these nurses, she says, stay away from their professional associations "in droves," and are largely alienated from the culture of

professionalism found in a minority group of elite and influential leaders. In the Alberta situation, the mainstream nurses resented the control of what may be regarded as the elite decision-makers on the AARN Provincial Council, and felt constrained by the prevailing professional culture, notwithstanding the autonomy given to the collective bargaining division under the revised bylaws.

The union leaders were able to articulate the values and aspirations of nurses representing the alienated and apathetic mainstream whose interests lay primarily in the work settings. In particular, Donahue was attuned to the mood of nurses in the staff nurse divisions, persuading them that self-interest and professional objectives were not incompatible. He promoted feelings of "we-they," fostering the segmentation of cultures and increasing the probability of high levels of discontent, not only with salaries and working conditions but with the style of representation in collective bargaining at the AARN. It was very much to his advantage that there were sound organizational bases and good communication networks within the AARN, because they enabled him to promote the independence movement. The combination of circumstances prevailing in the AARN at that time, namely, unhappiness with existing institutional guidelines, and the presence of able and willing leaders, strong organization, and communication channels are some of the necessary conditions which give rise to social movements, according to Clark, Grayson & Grayson (1975). Such conditions also are the precursors of strikes, according to Batstone, Boraston & Frenkel (1978).

The immediate history of the bargaining agent for nurses was a

significant determinant or cause of the first strike. The intraorganizational struggle within the AARN served the objectives of the more militant elements of the emerging trade union in demonstrating both the legitimacy and effectiveness of confrontation and conflict as a power-building and goal-attainment strategy. This aggressive approach to bargaining caught the employers' association somewhat by surprise in 1977, and was subsequently institutionalized as a union value and norm, both in interest and rights disputes thereafter.

Explaining the Strikes

As noted in Chapter 9, many causal factors were found to be true of all three strikes. The disputes occurred at a time when the province was experiencing an economic boom, inflation was high, and hospitals were contending with sharp increases in costs. Employers were locked into a system of prospective budgeting, last dollar government funding, and public wage restraint policies. Nurses were highly committed to their extraordinary demands, many of which were unresolved in the first strike and carried over to subsequent disputes. In essence, these problems were common to all three disputes and as such, seemed like a formula for impasse at the bargaining table.

The first strike was a continuation of the mobilization of nurses to establish an independent union and to distance themselves from the parent organization, the AARN. During the process of radicalization, as Donahue called it, nurses were promised a more effective means of dealing with the consequences of staff shortages, heavy workloads and questionable management practices. Heightened

expectations and a more permissive demand-setting procedure produced a package of demands that far exceeded what could be delivered to the membership through negotiation while wage controls were in place, and so the union had little choice but to use its strike weapon and to gamble on the intervention of government. The arbitrated settlement was a victory of sorts in that nurses had made their point about salaries, but almost none of their other leading concerns were addressed in the arbitrator's award.

The negotiation of a two-year agreement shortly after the final resolution of the first dispute was unremarkable, except for the achievement of the Rand Formula. Automatic payroll deduction of union dues and two years of labour peace allowed the union to concentrate on stabilizing its internal order and socializing its members to union ideology and operations. Preparation for the next round of negotiations occurred under the purview of a new leader, and the ferment that had spread "like the measles" two and a half years earlier again gathered momentum. On the largest wave yet of discontent and accompanied by feelings of invulnerability, the union launched its second strike. The militancy among the mainstream in nursing was founded this time on a better understanding of what could be achieved through a strike and a determination to correct the shortfall in the bargaining achievements of 1977 and 1978.

The fiscal dilemma of hospitals had not changed, nor had the organizational arrangements for collective bargaining within the AHA, except for the arrival of several new decision makers. Negotiations between the parties amounted to little more than game playing, while

the union exhausted the necessary legal steps before calling a strike. In view of the hard line position taken by the AHA at the bargaining table, its assumption that the strike was inevitable was accurate. Not only was the strike inevitable, but in view of the number of hospitals affected by the strike, intervention by the government was also inevitable. The union had no need to negotiate. The AHA was in disarray and once the Minister of Labour had been drawn into the final haggling, the union was assured of a better settlement than it could have achieved had it remained at the bargaining table.

The spirit of protest among nurses was sufficiently alive in 1982 for the union to try to repeat its successful performance of 1980. There was again a new leader and the same strategic plan unfolded at the negotiating table. The commitment of nurses to the cause, however, was faltering. The strike vote was won by a smaller majority than before, but the recommendations of the Disputes Inquiry Board provoked enough anger among nurses to carry them on into their third strike.

Previous successes of the union had served to ameliorate some of the sources of discontent among the members, and the protest movement began its decline when nurses crossed the picket lines of their longest strike. By 1984, the Alberta economy had entered a recession, and although the government had removed the legal right of nurses to strike, the protest had run its course; and by 1986, it was apparently spent--nurses voted to reject their leaders' call for what would have been an illegal strike.

If major confrontation was part of an overall game plan of union leaders, the issues over which the parties fought their battles were well chosen. The principal irritant in every dispute was the extent and complexity of the union's economic demands. For example, the salary demands alone so far exceeded convention with respect to an initial bargaining stance as to elicit ridicule from the management teams. Nurses said they were tired of being compensated on the basis of the "convenient social virtue" (Galbraith, 1973), and so the real issue was the comparable worth of a nurse's services. Establishing the comparable worth of jobs has been described by Disch and Feldstein (1986) as the civil rights issue of the 1980s. It is a difficult and complex task and one which the parties were unable to settle at the bargaining table. The reason for the impasse over salaries was due in large measure to the fact that the employers had neither the willingness nor the wherewithal to concede to the union's demands.

The non-economic or normative demands of the union revealed that nurses wanted to exercise more control over the context of nursing practice. Few demands could be expected to generate more resistance than such threats to managerial authority in the workplace. Nurses said that they were frustrated by the discrepancy in the standard of care they felt patients should receive and the actual care they were able to deliver. The solution to this problem, they felt, was to obtain provisions in the collective agreement that would give them a measure of control over how their services might be deployed and a forum for dealing with patient care problems, i.e., professional

responsibility committees. Allegations of improper management practices, far from justifying their case, drove a large wedge between the parties on the issue. There were other professional issues such as the demand for paid educational leave, but these were not among the more important demands over which the parties were prepared to wage economic warfare.

Although professional issues were central to the rhetoric and debate in these disputes, there was no evidence to suggest that they were more important to nurses than salaries, working conditions, job security, and work schedule rules to permit the normalization of lifestyles. In fact, some evidence was presented to suggest that employers were more sympathetic to professional issues, for example, to the need for maintenance of a nurse's registration, than they were to the more traditional types of union demands.

The volume and nature of the nurses' demands, together with the power of the union to make good its threat to disrupt the hospital system placed immense strain on the fragile alliance of the AHA membership. The multi-employer/single union structure of bargaining agreed to by the parties had served them well since the earliest days of their collective bargaining relationship because, on the whole, they had found that the advantages had outweighed the disadvantages. The history of the AHA attested to the fact that under ordinary circumstances, it had often been difficult to reconcile the particular interests of a very diverse membership. Under duress, as in the case of these disputes, large and small hospital boards found it difficult to agree on some of the more complex issues. The diffuse

and hierarchical decision structures for labour relations were rendered inefficient, and in one case, they seriously undermined the authority of the bargaining team. The surrender of authority by hospital boards to deal with specific operating matters is one of the more vexing disadvantages of multi-employer bargaining structures (Abelow & Metzger, 1976).

On one point there was widespread agreement among employers. They would not authorize their bargaining teams to exceed the prevailing wage controls built into hospital budgets without firm guarantees of deficit funding from the government. Not only was this position felt to be consistent with public policy and responsible management, but employers held definite views as to the appropriate rate of pay for nurses, and they were not convinced that their working conditions were unreasonable. Although technically an independent entity, the AHA chose not to go beyond the dictates of its member institutions and was, therefore, incapable of independent action without the assistance of the government in solving these particular sociopolitical problems.

The structure of bargaining was de facto a multilateral arrangement between employers, union, and government. The power of government, or of any third party payer, to withhold or grant reimbursement monies during contract discussions, as Bohlander (1980) says, is an enormous weapon. The parties were not oblivious to the tripartite nature of collective bargaining in the hospital industry, and because the union regarded the AHA as a front for the government, it can be concluded that its economic warfare was as much against the govern-

ment as it was against the employers' association. It was to the advantage of both parties to draw the government into the negotiations and into the strikes because settlements had eluded them at the bargaining table. If the parties had assumed that one of their options was to induce government intervention, even as a last resort, then much of the skepticism and cynicism reported during negotiations can be explained; making concessions at the bargaining table would seem to have been counter-productive to goal achievement if such assumptions had been made, or indeed, if such tactics had been part of their overall plans.

The nature of the collective bargaining relationship during these disputes was clearly one of the major reasons for disagreement between the parties. The character of collective bargaining relationships is determined by the pattern of interaction between the representatives of union and management, and there is little question but that a major change in the relationship occurred in 1977. Prior to that date when the AARN represented nurses, the relationship between the parties had developed into one of mutual respect, or to use a classification scheme of Selekman, Selekman, and Fuller (1958), one of accommodation and cooperation. The parties recognized the legitimacy of each other, they understood the scope of concerns of each other, and if conflict occurred they were generally willing to deal constructively with it. The new union leaders adopted the position that it was time to change the image of nurses as willing to cooperate and compromise, and to attack what they considered to be stereotypical thinking of employers in relation to their nursing employees.

The relationship between union and management took on a fractious quality that was characterized by conflict on the part of the union and containment on the part of employers (Selekman et al., 1958).

The sheer newness of the union's approach to bargaining in the first dispute forced the employers into a defensive stance. Employers were firmly resolved to minimize concessions to the union as it pressed to broaden the scope of bargaining issues. The manifest resistance of employers, and the fact that unresolved issues were carried over from dispute to dispute, served to animate the spirit of protest among union members. Shortages of staff, unsatisfactory working conditions, perceived under-valuation of their services, and lack of respect on the job all justified to union members the aggressive position being taken by their leaders. Although collective bargaining implies conflict over the distribution of scarce resources, it requires cooperation if agreement is to be the final outcome. During these disputes the collective bargaining relationship regressed to what might be described as a state of immaturity not witnessed before, which virtually precluded any form of cooperation.

In conclusion, an argument has been made that the principal causes of the strikes lay in a combination of several phenomena, namely: union militancy; certain structural aspects of bargaining in the public sector; and economic factors. The strikes were primarily symptoms of a broader based, but highly structured, social movement of protest among nurses. Union leaders skillfully exploited their various sources of power, particularly the dissatisfactions of a

homogeneous and educated membership; the issues in dispute; the essential nature of nursing services for maintaining hospital services; the legal system; and the political and economic climate in the province. In so doing, the union out-manoeuvred the employers' association which was constrained by its own goals and membership characteristics; the source of hospital funding; wage restraint policies; and by its intraorganizational dynamics. The strikes took place at an unusually prosperous time in the province's economic history, and the issues in dispute were closely linked to those economic and social forces.

Implications of the Study

The Collective Bargaining Relationship

The conclusions reached above lead to the question of what lies ahead for the collective bargaining relationship. How might the parties improve on a relationship which in the past has bordered on a pathological state? Under what circumstances are nurses likely to withdraw their services again? Although the Alberta Government has changed the collective bargaining rules since these disputes outlawing strikes by hospital employees, such legal prohibitions will not necessarily guarantee the absence of work stoppages in labour disputes.

Compulsory interest arbitration has been rejected by the United Nurses of Alberta (UNA) as a tool of government because arbitrators are now required under the law to take into account public fiscal policy when issuing their awards. The evidence presented in this study suggests that the potential for government intervention in the

disputes and the imposition of compulsory interest arbitration had a negative impact on the bargaining process and on the sincerity of the parties at the negotiating table. The negative effects of interest arbitration on negotiations have been well documented (Weiler, 1981), but the experience of Ontario nurses with this form of conflict resolution suggests that positive effects are also possible. The propitious use of compulsory interest arbitration by Ontario nurses has persuaded them that they have no need to acquire the legal right to strike (Anne Gribben, personal communication, August 15, 1983). In the case of Alberta nurses, significant economic gains were made by virtue of interest arbitration which could not apparently be attained at the negotiating table. There are other variations of interest arbitration, for example, final offer or mediation-arbitration, that might be considered by the parties as a means of reducing the negative effects on negotiations.

The structural aspects of bargaining and of hospital funding which were seen to have contributed to these disputes are unlikely to change in the immediate future. Hospitals will continue to grapple with rising costs and governments will continue to search for ways of containing health care expenditures. It would seem that all parties involved need to come to terms with the limits to public funding on health care prior to the start of collective bargaining and prior to the submission and finalization of hospital budgets. If they fail to do so, these integral dimensions of collective bargaining in the hospital industry will remain a potential threat to future labour peace.

The UNA has been successful in addressing the concerns of its members. As a result of the strikes, the salaries of nurses more than doubled in the six-year period. The contentious salary differential between aides and registered nurses in the first dispute rose from 12 percent in 1977 to 28 percent (on average) in 1982 (Virginia Braxham, Alberta Association of Registered Nursing Assistants, personal communication, August 1, 1986). Many other significant improvements were made in the terms and conditions of employment, including the controversial professional responsibility committees that employers said "they would not live with."

These disputes were primarily caused by nurses protesting the inequity of their relative compensation and the quality of their working lives. Protests over the maintenance of acceptable standards of nursing practice have occurred in other provinces (see, for example, Lovell, 1981), which suggests that nurses will not tolerate situations in which they must provide unsatisfying nursing services in the workplace. In the event that the salaries and fringe benefits of nurses fail to keep pace with the compensation of workers having comparable skills, education, and responsibility, and where purchasing power has been objectively eroded, nurses are likely to repeat their struggles of the past. Moreover, nurses can be expected to protest any circumstances in which human and material resources are allocated in such a manner as to reduce their capacity to provide standards of practice that are acceptable to them.

Nurses are unlikely to tolerate working conditions which render them vulnerable to legal liability or to professional discipline.

Any attempt by employers to dilute the existing collective agreement or to obtain concessions from the union on issues of importance to the majority of nurses would almost certainly lead to an impasse in bargaining. The issues of importance to nurses are those that offer them some form of control over their lifestyles, that offer job security, and that give them a voice in the management of their immediate working environment. However, these are merely tentative propositions because, above all else, this study reveals that the reasons why Alberta nurses withdrew their services were highly complex.

Contribution of the Study to Theory

In some respects, little has been added by this study to what is already known about strikes as a general class of social conflict. These strikes by nurses were characterized by most of the classical elements of union-management conflict over the renewal of collective agreements. The contribution of the study rests mainly on the perspective it offers of a collective bargaining relationship in the Canadian public sector, or more specifically, in the parapublic sector. The detailed examination of the intraorganizational dynamics within both the nurses' professional association and the employers' hospital association, as well as the evolution of a nurses' union, provide information which has both practical value for the parties and academic interest for students of labour relations in the health field.

The development of collective bargaining by nurses was found to follow quite closely the general path of other public sector employee

unions (see Ponak, 1982), except that, in this case, three distinct phases in the process were identified. One question of historical interest is whether such an organizational pattern can be generalized to other Canadian nurses' unions. Although this is an historical case study, it should not be regarded as a definitive history of collective bargaining by nurses in Alberta as its primary focus was on a limited time frame. Further, many individual nurses and employers' representatives, who made significant contributions to the particular structure of bargaining that evolved, have received scant attention, if any, because of the particular scope and objectives of the research. A more comprehensive approach to the history of labour relations in the health field would be of considerable practical and academic value.

The causes of the strikes were found to be multiple and inter-dependent whether the disputes were considered individually or as a series of similar events. Some causal factors appeared to have had a cumulative effect on events at the bargaining table. The problem of explaining strikes at the level of the collective bargaining level, as Kochan (1980) says, is one of great theoretical complexity, and the conclusions reached above suggest that a combination of socio-political and economic theoretical approaches is required for a sufficient causal analysis of strikes at this level.

Some evidence of bi-culturalism in the nursing profession was presented, but to what extent nurses themselves recognized such a phenomenon was not examined. It would seem, however, that by subscribing to the values of a work culture nurses might find it easier

to rationalize withdrawal of their services than if they subscribe to values associated with the service ideal. The union argued that when on strike a nurse had no obligation to employers and, therefore, none to patients. Was this merely rhetoric or do nurses turn professional values on and off as they come and go from work? If such is the case, what are the practical and professional implications of a work culture in the "mainstream" of nursing? These would seem to be interesting questions for further inquiry.

Management of Nursing Resources

The study was not designed to assess the validity of allegations of improper management practices made by union leaders in these disputes, but the situations described by nurses to the Public Arbitration Tribunal of 1982 were not inconsistent with the work lore of hospital based nursing practice. Inasmuch as staff nurses in hospitals are supervised by their colleagues in nursing management positions, there would seem to be some implications for nurse managers if the allegations were founded on fact. This study is almost silent on the role played by nurse managers in the disputes; they substituted for staff nurses during the strikes and a few of them served on the AHA negotiating teams. Only one of the nurse managers interviewed reported that she felt an obligation to interpret the role of staff nurses to her non-nurse managerial colleagues.

The nature of the issues raised during the disputes and the ramifications for hospitals indicates that effective management of nursing resources in contemporary hospitals requires well qualified administrative personnel, both in charge of hospitals and in charge

of nursing service departments. Leatt (1981) reports that the education of nurse administrators in Canada is both inadequate and insufficient. In Alberta, more than 32 percent of nurses in senior management positions in nursing have no preparation beyond a basic diploma in nursing and similarly, more than 47 percent of first line managers in nursing have had no management education (Letter from Janet Nellis, AARN Computer Operator, dated October 9, 1986). These figures indicate that there is a need to promote educational programs in nursing management, and to provide access to such programs for incumbents and potential incumbents of nursing management positions in Alberta health care agencies. In view of the implementation of professional responsibility committees following the strikes by nurses, one important challenge for nurse managers in hospitals will be to deal with the problems raised by staff nurses before they become the basis of arguments in interest disputes.

In summary, the first two of the investigator's research objectives were achieved but the third was only partly achieved. The first objective was to provide an historical record of the strikes by Alberta nurses during the years 1977 to 1982, and the second was to identify their causes. The third research objective was to develop the elements of a theory that would explain why the labour disputes occurred. Although several propositions were advanced, it was concluded that they did not add substantively to existing theory of the determinants of strikes at the collective bargaining level of the labour relations system. The content and analysis of this study, however, are expected to provide a useful source of information for future research aimed at theory development.

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APPENDIX A

Chronology of the 1977 Strike

APPENDIX A

Chronology of the 1977 StrikeThe Parties:

1. Alberta Hospital Association (AHA) representing 68 hospital boards.
Negotiator: Leo Lancaster, later succeeded by Tom Grothen, AHA staff.
2. Alberta Association of Registered Nurses (AARN) representing 6000 registered nurses.
Negotiator: Bob Donahue, Acting Director, Collective Bargaining Division, later Chief Executive Officer, United Nurses of Alberta.

1977

- January Negotiations begin. Stalemate is reached after six bargaining sessions. Application for conciliation services is made.
- Nurses' major demands:
- average salary increase of 36.8%, to re-establish appropriate differential between nursing aides and registered nurses, and to gain parity with registered nurses in British Columbia and Saskatchewan.
 - committee on nursing
 - 1 weekend off in 3
 - day shift work for one third of the time
 - paid educational leave
 - benefits for part-time nurses
 - the Rand formula for dues deduction
- February 23 Staff Nurse Divisions of the AARN vote 84 to 2 in favour of increasing collective bargaining dues to half of one percent of basic salary, from \$50 per annum.
- April The parties begin meetings with W.M. Pangrass, a conciliation commissioner; 20 items either withdrawn or agreed upon. AHA makes money offer of 6% increase consistent with wage and price controls. Conciliation fails.
- April 18 Donahue outlines complete strike plan in memorandum to St. Michael's Hospital Staff Nurse Division, Lethbridge.

1977

- May 6 Nurses announce plans to separate from the AARN and to establish an independent union, the United Nurses of Alberta (UNA).
- May 18 The Minister of Labour accepts the report of the conciliator recommending that the parties decide to strike or lockout.
- May 20 Nurses file the constitution of the United Nurses of Alberta with the Board of Industrial Relations.
- June 9 Strike vote begins in 68 hospitals. All but 9 Staff Nurse Divisions vote in favour of strike.
- July 4 Strike begins in 7 major hospitals: Grande Prairie General; Royal Alexandra, Edmonton; Edmonton General; Red Deer General; Calgary General; and St. Michael's, Lethbridge.
- July 8 Strike notices are served in 23 additional hospitals.
- July 9 A state of emergency is declared by Order in Council of the Lieutenant Governor under section 163 of the Alberta Labour Act. The strike ceases at 6:00 p.m.
- July 20 Minister of Labour establishes a Public Emergency Tribunal, and appoints Mr. Justice D.H. Bowen as sole arbitrator.
- July 28 Informal meeting of Judge Bowen and the parties. Twenty-nine items remain in dispute.
- August 8-10 Public Emergency Tribunal hearings, 3 days in total.
- August 24 3000 hospital support staff are awarded a 6% across-the-board pay increase by an arbitration board.
- August 25 Award of the Tribunal is released:
- pay increase of 9% across-the-board
 - one-year contract (AARN's demand)
 - 17 other economic demands rejected
 - Rand formula, concessions to part-time nurses, and committee on nursing all denied

The arbitrator concluded that he was not bound to follow strictly the anti-inflation guidelines by virtue of his appointment pursuant to the emergency provisions of a provincial labour statute.

1977

- September 6 The AHA applies to the Anti-Inflation board for a ruling on the award, as employers are liable for prosecution if they exceed the wage and price guidelines.
- September 9 The United Nurses of Alberta announces it will strike on October 6th if the full arbitration award is not paid: "Nurses are not about to be made fools of" Bob Donahue says.
- September 15 The AHA advises its member institutions to pay the 6% increase to nurses according to the anti-inflation guidelines, holding 3% in trust until the Anti-Inflation Board makes a ruling on the award.
- September 19 Minister of Labour enters the Tribunal's Award as an official court ruling. UNA announces that it will apply to the Supreme Court of Alberta for a writ of execution.
- September 22 The federal Anti-Inflation Board announces its decision to roll back the 9% salary increase awarded to nurses to 6%.
- September 23 The UNA announces it will appeal the Anti-Inflation Board ruling.
- October 8 Nurses decide against another strike, but begin filing individual affidavits with the Sheriff of Land Title Office.
- October 12 Minister of Labour announces on the first day of the new legislative session, that the Provincial Government will amend its agreement with the Federal Government, and enforce the emergency provisions of the Alberta Labour Act. This will enable nurses to receive their ~~full salary~~ award of 9%.
- November 25 The collective agreement imposed on the parties by arbitration is signed.

APPENDIX B

Chronology of the 1980 Strike

APPENDIX B

Chronology of the 1980 StrikeThe Parties:

1. Alberta Hospital Association (AHA) representing 86 hospital boards, three of which are governed by public service labour legislation.
Negotiator: Bob Owen, AHA staff
2. United Nurses of Alberta (UNA) representing 6600 registered nurses.
Negotiator: Simon Renouf, Executive Director, UNA

1979

- October 16 Negotiations begin. Ten bargaining sessions are held and talks break down. The UNA charges that the AHA has not made a money offer. A spokesman for the AHA reports that the UNA has a 170-item "shopping list" equivalent to a 76% increase on existing contract.
- Nurses major demands:
- wage increase of 33.3% in the first year of contract
 - professional responsibility committee
 - improvements in work schedules with 1 weekend off in 2, and increased vacations
 - 24-hour day care services
 - portability of benefits
 - paid educational leave
 - employer-paid premiums for health care insurance, long-term disability, and dental plans
- November 22 The UNA makes application for conciliation services. Thirty-seven of 207 items in dispute have been settled; of the remaining 170 the UNA has proposed amendments to 107, the AHA has proposed amendments to 44, and both parties have proposed amendments to 19.
- November 29 The Minister of Labour appoints John Peters as conciliation commissioner.
- December 11 The Alberta Government announces wage guidelines of 7.5%-9% for 1980.
- December 14 Conciliation breaks down.
- December 21 The AHA makes application for arbitration of the dispute on behalf of the three hospital boards and union locals that are governed by the Public Service Employee Relations Act, (PSERA).

1980

- January 3 The Minister of Labour is reported to have received
the conciliator's report.
- January 9 The AHA and the Health Sciences Association of Alberta
reach agreement on a 17.5% wage increase over a
2-year contract. The agreement is ratified by 54
locals, and rejected by 23 locals.
- January 10 The Minister of Labour meets with the parties
individually.
- January 22 Mediation fails and the Minister of Labour establishes
a Conciliation board to deal with each item in
dispute, as recommended in the earlier conciliation
report. The recommendations will not be binding on
the parties.
- January 28 The AHA application for arbitration of the dispute
under the PSERA is denied on the grounds that the
parties have failed to make a reasonable effort to
conclude collective bargaining.
- February 12 Negotiations between the provincially-owned hospitals
and nurses under PSERA break off. The AHA has
offered 21.5% wage increase over three years; 7.5%
in the first year and 7% in each of the next two
years.
- February 14 Under the provisions of the Alberta Labour Act (ALA),
the UNA nominates Lynn Oscroft to the Conciliation
Board, and the AHA nominates Ken Barrass. The two
nominees cannot agree on a chairman for the Concili-
ation Board.
- February 19 Nurses mount media and political campaigns.
and 20 Newspapers report: Nurses are in tougher mood than
in 1977; they want a fair deal; strike is a real
possibility. Letters are sent to Members of the
Legislative Assembly. Paid advertisements appear in
newspapers around the province.
- February 22 Gerry Lucas, an Edmonton lawyer, is named to the
Conciliation Board. Closed door hearings begin.
The UNA and AHA jointly apply for a mediator in the
provincial hospitals' dispute, i.e. under PSERA.
- March 11 Conciliation Board is granted an extension of time
limits under ALA. Ninety-one items still in dis-
pute.

1980

- March 17 Conciliation Board Chairman requests a second extension of time limits until March 28.
- March 20-22 Newspapers report frustration and anger among nurses with the delay in settling their dispute. The union local at the Holy Cross Hospital, Calgary, threatens a call-in-sick campaign and nurses defy hospital dress code.
- March 31 to April 8 Several hospital boards direct the AHA to inform the Minister of Hospitals and Medical Care that they cannot cope with a full nurses' strike.
- March 28 Conciliation Board's report is handed down and deals with 70 items in dispute. Recommendations include:
- wage increase of 12% in 1980, and 10% in 1981 over a two-year contract
 - increases in educational premiums
 - increments in wages for part-time nurses to be based on accumulated hours of work
 - a professional responsibility committee to be set up at the provincial level rather than within each hospital as demanded.
- April 1 The UNA rejects the Conciliation Board's report, while the AHA accepts the report as a basis for settlement.
- April 3 Arbitration date is set for April 12 to deal with the dispute of the provincial hospitals under PSERA. Under this legislation, six of the items in dispute are non-arbitrable including hours of work, and the professional responsibility committee demand.
- April 10 The AHA makes an improved offer to the UNA. Telex messages are sent to all hospital administrators requesting them to post the offer: 19.15% increase at the start of the salary scale, and 15.27% at the top of the scale for 1980; a 10% general increase in 1981; other benefits amounting to 3% increase giving parity with Ontario nurses; and a letter of understanding with respect to professional responsibility committees.
- AHA press release in Edmonton announcing the formation of a special task force to coordinate the scaling down of hospital services in preparation for a nurses' strike. The union is requested to extend the statutory 48-hour notice of intent to strike, and to maintain essential services.

1980

- April 12 12,500 British Columbia nurses settle for 44% salary increase over a 27-month period, following a strike threat.
- April 14 Alberta nurses take strike vote. 6600 eligible voters. 5700 cast votes, 5400 (95%) vote in favour of strike.
- April 15 Strike notices are served in 81 hospitals, effective April 18.
- April 17 Minister of Labour responds to a question in the Alberta Legislature, saying that he is involved "eyeball to eyeball" in the nurses' dispute.
- The Red Deer General Hospital nurses' local informs the hospital Board that it will have to rely totally on supervisory nurses to provide emergency services.
- April 18 Strike begins in 81 hospitals by 6400 nurses.
- April 21 A state of emergency is declared by Order in Council of the Lieutenant Governor, directing the strike to cease at 1:00 p.m.
- 500 nurses assemble at the Legislature announcing that they will not go back to work.
- April 22 The UNA initiates legal procedures to challenge the validity of the Order in Council.
- April 23 The Minister of Hospitals and Medical Care responds to a question from the Opposition in the Legislature, announcing that there is a commitment to finance either a voluntary, or an imposed settlement.
- April 25 Negotiations between the parties resume at 5:00 p.m., breaking off at 6:15 a.m., April 26th. The Assistant Deputy Minister of Labour meets with the parties. Negotiations continue sporadically.
- April 27 Agreement is reached.
- April 28 The memorandum of agreement is flown to Calgary by government jet and is signed by Judge Brennan, appointed as the sole arbitrator of a Public Emergency Tribunal by the Minister of Labour.
- Major gains over the Conciliation Board recommendations:

1980

- wage increases to be staggered over three steps of two-year agreement equal to 39.8% at the start rate
- professional responsibility committees to be established in each hospital
- work schedule improvements, 1 weekend off in 3, schedules to be posted 4 weeks in advance
- weekend to be defined as 56 continuous hours
- part-time nurses scheduling improvements
- performance evaluation rights
- dental plan
- over 50 other contract improvements

Nurses return to work.

APPENDIX C

Chronology of the 1982 Strike

APPENDIX C

Chronology of the 1982 StrikeThe Parties

1. Alberta Hospital Association (AHA) representing 92 hospital and nursing home boards.
Negotiator: Ken Barrass, Management Consultant.
2. United Nurses of Alberta (UNA) representing 8955 registered nurses.
Negotiator: Simon Renouf, Executive Director, UNA.

1981

- October 18 Parties meet to exchange proposals.
- October 26 AHA press release claims that if the UNA is successful in its demands, 635 more nurses will be needed to staff hospitals, and the cost to the public will increased by 75%.
- October 27 Negotiations begin.
- Nurses major demands:
- wage increase of 40-52%
 - work schedule changes, schedule to be posted one year in advance
 - hours of work, 1 weekend off in 2, and vacation improvements
 - no compulsory overtime
 - 2 additional statutory holidays
 - removal of wage differential between registered and non-registered nurses
 - safety measures for nurses
 - external adjudication of problems arising from professional responsibility committees
 - 229 demands in total including 98 new contract clauses
- It is reported that there are 640 registered nurse vacancies in the province equal to an 8.7% vacancy rate.
- November 12 Slow progress in talks. The AHA applies for mediation services.

1981

- November 25 The Alberta Association of Registered Nurses (AARN) places advertisements in various Alberta newspapers in response to the UNA's demand on registration: "Abolition of registration must not be allowed to happen." Simon Renouf comments that some UNA members no longer want to continue registration with the AARN in the absence of mandatory licensure. Eliminating the differential means no more "financial discounts" for employers who hire non-registered nurses.
- December 15 The AHA offers a wage increase of 17.6% for 1982, and an increase equal to the Consumer Price Index for 1983; increases in other benefits; and to finance a study related to work schedule demands.
- December 19 Talks break down.
- December 21 Strike vote is held in 90 hospitals. Sixty-four percent of the UNA's membership votes, 75% in favour of strike. Sixty-one union locals vote to strike.
- December 24 Alberta physicians settle for a 21% increase in fees, and are now the highest paid in Canada.
- December 29 Strike notices are served by nurses, effective January 1st.
- December 31 Minister of Labour invokes provisions of new labour legislation, appointing Erik Lefsrud, Q.C. to the first ever Disputes Inquiry Board (DIB).

1982

- January 1 The seven-member Employment Relations Officers' union of the UNA go on strike. The issues are wages and hours of work. A 25% pay increase is demanded, and settlement is reached after six weeks of strike with a 13% pay increase.
- January 6 The DIB convenes. There are 151 items in dispute between the parties. The UNA is demanding a 35% pay increase; every second weekend off guaranteed; shift schedules to be posted one year in advance. Twelve days of meetings are held.

1982

- January 8 The AHA sets up a 4-person task force of senior nurses to study work schedules and the impact of nurses' demands.
- January 12 The Provincial Government releases compensation guidelines for the public sector, including a salary component of no more than 12% for 1982.
- February 5 The DIB report is received by the parties in the dispute. The Minister of Labour orders nurses to vote on the recommendations of the report on February 11, announcing that the vote will be "final and binding." The report recommends:
- wage increase of 17.5% in 1st 6 months of the contract
 - wage increase of 7.5% in 2nd 6 months of the contract
 - wage increase of 12.0% effective January 1, 1983
 - 2 weekends off in 5 (down from 2 in 6)
 - day shift 40% of the time
 - work schedules to be posted 12 weeks in advance
 - no change in professional responsibility committees
 - differential between pay of registered and non-registered nurses to remain the same
- February 9 The UNA urges its members to boycott the government sponsored vote. Margaret Ethier, President of the UNA is quoted as saying: "We will not allow ourselves to be steam rolled by this government." Copies of the DIB report go to all UNA locals.
- February 11 1000 nurses vote in the government-sponsored vote: 75% vote in favour of the DIB recommendations.
- February 12 6127 nurses vote in a union-sponsored vote: 69% reject the DIB recommendations.
- The AHA accepts the DIB recommendations "with extreme reluctance as to the implications for funding."
- February 15 A meeting is held between the AHA, Ministers and Deputy Ministers of Labour, and Hospitals and Medical Care respectively, to decide if a collective agreement can be declared in place in the hospitals where nurses accepted the DIB recommendations. Neither side in the dispute is in favour of making the necessary application to the Labour Relations Board for a ruling.

1982

- February 15
(cont'd) Last ditch weekend negotiations fail. The AHA will only negotiate within the provisions of the DIB report; the UNA wants to make improvements to the DIB recommendations.
- February 16 Strike begins in 60 hospitals.

Hospitals have planned systematically for this strike. Physicians and public opinion are less supportive of nurses. Hospital Boards resolve to stand firm.
- February 20 A meeting is held at the College of Physicians and Surgeons with the AHA and the UNA representatives to discuss the position of the nurses with respect to the provision of emergency services.
- February 22 Talks between the parties resume.
- February 23 The AHA reports that 650 nurses have returned to work.

A mediator, Dick Campion, is called in to mediate -- the parties are taking a hard line.

The President of the UNA is admitted to hospital for emergency surgery.
- February 24 Negotiations break off. The UNA states that salaries are no longer an issue, but that working conditions and hours of work are the central issues in the dispute.
- February 25 The Alberta Status of Women Action Committee organizes a rally of 300 in sub-zero weather, with the slogan "Working conditions are real issues."
- February 24
March 5 Charges and counter-charges are made between the parties on the question of nursing support for emergency services.
- March 5 The Premier, the Minister of Labour, and the Minister of Hospitals and Medical Care meet with the College of Physicians and Surgeons to discuss the state of medical and health care services in hospitals. Documented evidence of a growing volume of people requiring urgent medical interventions is presented. The Council of the College of Physicians and Surgeons recommends abolition of strikes in the hospital field.

1982

- March 10 The Alberta Government introduces Bill 11, Health Services Continuation Act in the Legislature. Bill 11 receives three readings in one day, and is passed by 58 votes to 3 against. (Nurses pack the galleries and are twice asked to be silent). Nurses are ordered back to work under this legislation, with extraordinary penalties for non-compliance, including decertification of the union if necessary. The Minister of Labour defends the policy by saying both parties have failed in their responsibilities.
- March 11 Nurses return to work en masse. Widespread condemnation of the legislation is expressed by the public and the parties to the dispute.
- March 23 The Edmonton Journal publishes a letter from ten university law professors describing Bill 11 as "a dangerous precedent for oppression."
- March 24 By Ministerial Order, an Arbitration Tribunal is constituted: Mr. Justice G.R. Forsyth as Chairman, and Mrs. C.M. Wood and Mr. H.L. Spelliscy as members.
- May 3 - June 25 Sixteen days of public hearings are held alternately in Calgary and Edmonton.
- July 16 The Arbitration Tribunal Award is released:
- wage increase of 20% for 1982, and 9% for 1983 (8% less in total than DIB recommendation)
 - 12 week advance posting of work schedules
 - 2 weekends off in 5
 - no more than 6 consecutive shifts to be worked
 - 14 days notice of shift change
 - no nurse to work alone
 - no change in overtime requirements
 - differential between registered and non-registered nurses to remain unchanged
 - access given to Hospital Board to resolve problems arising out of professional responsibility committees
 - various other improvements to the contract
- This award is final and binding on the parties.

APPENDIX D

The Strategic Informants

APPENDIX D

The Strategic Informants

Barrass, Ken

Engineer and Management Consultant.

AHA negotiator, 1981/1982.

Consultant to Alberta Association of Registered Nurses,
1965-1973

(November 20, 1983).

Bennett, Jane

Employment Relations Officer.

Alberta Association of Registered Nurses, 1976-1977.

(April 2, 1984).

Baird, Richard E.

Associate Professor, Political Science, University of Alberta.

(February 10, 1984).

Chapman, Yvonne

Executive Director, Alberta Association of Registered Nurses
since 1976. Director of Collective Bargaining Division,
1970-1976.

(September 29, 1983).

Charbonneau, Joan

President, Royal Alexandra Hospital Staff Nurse Division
1973-1975.

Chairman, Provincial Staff Nurse Committee, Alberta Association
of Registered Nurses, 1975-1976.

(February 7, 1984).

Chinell, Gurty

Chairman, Provincial Staff Nurse Committee, Alberta Association
of Registered Nurses, 1977

President, United Nurses of Alberta, 1977-1980.

(October 24, 1983).

Clarke, Donna

Member of the United Nurses of Alberta Negotiating Committee
1977-1982.

Vice-President of the United Nurses of Alberta, 1983.

(September 21, 1983).

Connolly, Walter R.

Manager, Labour Relations, Edmonton General Hospital.

Member of the Alberta Hospital Association Negotiating Team
every year except 1980/1981

(September 9, 1983).

Coombs, Ralph

President, Foothills Hospital, Calgary.

President of the Alberta Hospital Association, 1975/1976.
(September 20, 1983).

Cranston, Lynda

Senior Vice-President-Operations, Calgary General Hospital.

Member, Alberta Hospital Association Negotiating Team,
1981/1982.

(September 20, 1983).

Currie, William

Director of Human Resources, Metropolitan Calgary and
Rural Hospital District No. 93.

Member, Alberta Hospital Association Negotiating Team,
1979/1980.

(September 22, 1983).

Dancause, Annette

Staff Nurse, Edmonton General Hospital.

Former President, United Nurses of Alberta, Local 79.
(May 7, 1984).

Dolan, Agnes

Director of Special Units, Nursing Department, Edmonton
General Hospital.

Member of the Alberta Hospital Association Negotiating Team,
1979/1980.

(September 9, 1983).

Donahue, R.R. (Bob)

Employment Relations Officer, Alberta Association of
Registered Nurses, 1973-1976.

Chief Executive Director, United Nurses of Alberta, 1977-1979.
(October 29 and 30, 1983).

Embury, Sheila

Member of the Legislative Assembly for Calgary North West.

Former Provincial Council Member, Alberta Association of
Registered Nurses, 1976-1977.

(March 12, 1984).

Ethier, Margaret

Staff Nurse, Edmonton General Hospital.

President of the United Nurses of Alberta, 1980-
(September 23, 1983; March 16, 1984).

Ewart, Shelley

Manager, Labour Relations, Metropolitan Calgary and General Hospital District No. 93.

Former Chairman, Negotiating Committee, Holy Cross Hospital Staff Nurse Association, Calgary.

Member of Task Force on Scheduling hours of work, Alberta Hospital Association, 1981/1982.

(September 22, 1983).

Fleck, Pauline

Director of Nursing, Sturgeon General Hospital.

Member of the Alberta Hospital Association Negotiating Team, 1979/1980.

(September 8, 1983).

Frauenfeld, Evelyn

Staff Nurse, University of Alberta Hospitals.

Vice-President, United Nurses of Alberta Local 32, 1979-1981.

(February 2, 1984 by telephone).

Gillis, Donna

Employment Relations Officer, United Nurses of Alberta, 1977.

(August 8, 1985 by telephone).

Gribben, Anne

Executive Director, Ontario Nurses' Association.

(August 15, 1983).

Grothen, Tom T.

Consultant/Negotiator, Alberta Hospital Association, 1977 and 1978

(August 26, 1983).

Harrison, Fernande, P.

Vice President-Patient Services, Foothills Hospital, Calgary.

(September 21, 1983).

Heise, Robert M.

Assistant Executive Director, Employee Relations, Alberta Hospital Association, 1981-1983.

(January 13, 1982; June 30, 1983; August 17, 1983; August 31, 1983).

Knight, Ed. H.

President, Calgary General Hospital.

President, Alberta Hospital Association, 1982/1983.

(September 21, 1983).

Lamb, M.H. (Scotty)

Director, Institutional Operations Branch, Department of Hospitals and Medical Care.

(December 8, 1983).

le Riche, L.H. (Roy)

Executive Director, College of Physicians and Surgeons
of Alberta.
(October 13, 1983).

Lorenz, Thelma

Staff Nurse, Glenrose Rehabilitation Hospital.
President, United Nurses of Alberta Local 32, 1977-1982.
(November 22, 1983).

Mellors, Clint S.

Assistant Deputy Minister of Labour.
Former Director of Personnel, Royal Alexandra Hospital, Edmonton.
Member of the Alberta Association Negotiating Team, 1979/1980.
(October 13, 1983; October 20, 1983).

Macgregor, D. A.

Executive Director, Alberta Hospital Association.
(June 8, 1983).

MacPherson, Madeline (née Quirk)

Chairman, Committee on Employment Relations, Alberta
Association of Registered Nurses, 1964-1965.
Director of Nursing, Red Deer General Hospital, 1963-1977.
(July 3, 1985).

Mearns, Michael J.

Employment Relations Officer, United Nurses of Alberta.
(September 23, 1983).

Moore, Janice

Director, Management Analysis and Planning Services,
Alberta Hospital Association.
Principal author of AHA Nursing Manpower Study (1980).
(December 7, 1983 by telephone).

Mrazek, Margaret

Vice-President, Patient Care Services, Misericordia Hospital,
Edmonton.
Member, Alberta Hospital Association Negotiating Team, 1977
and 1978.
(July 3, 1984).

Newhouse, Joseph R.

Member of the Alberta Hospital Association Employee Relations
Committee, 1979-1980
(May 26, 1986)

Owen, R.A. (Bob)

Consultant in Employee-Employer Relations.
Consultant/Negotiator, Alberta Hospital
Association 1979/1980.
(August 30, 1983).

Pals, Francis M.

President, Alberta Hospital Association, 1981/1982.
Member, Alberta Hospital Association Negotiating Team, 1979/1980.
Trustee, Our Lady of the Rosary Hospital, Castor, Alberta
(October 11, 1983).

Pedden, John

Director of Collective Bargaining, Alberta Hospital
Association.
(March 28, 1982; February 3, 1984).

Renouf, Simon

Executive Director and Negotiator, United Nurses of Alberta,
1979-1985.
(September 23, 1983; February 28, 1984).

Rheault, E.L. (Verne)

Director of Employee Relations, Alberta Hospital Association,
1977-1979, and later Assistant Executive Director, Employee
Relations and Consulting Services, 1979-1980.
(December 4, 1983 by telephone).

Ross, Murray

Executive Director, Alberta Hospital Association, 1959-1978.
(October 17, 1983).

Sabin, Helen

Executive Director, Alberta Association of Registered Nurses,
1960-1977.
(November 7, 1983; October 16, 1986).

Spelliscy, H.L.

General Manager, Hudson's Bay Company.
Member, Public Arbitration Tribunal, 1982.
(June 13, 1984).

Tod, Louise

Executive Director, Manitoba Association of Registered Nurses.
Employee Relations Officer, Alberta Association of Registered
Nurses, 1964-69.
(August 16, 1982).

Young, Hon. L.G.

Minister of Labour, Province of Alberta, 1979-1986
(March 12, 1984).

APPENDIX E

Correspondence with the Alberta Hospital Association

APPENDIX E.

Correspondence with the Alberta Hospital Association

FACULTY OF EDUCATION
DEPARTMENT OF EDUCATIONAL
ADMINISTRATION



THE UNIVERSITY OF ALBERTA
EDMONTON, CANADA
T6G 2G5

3 May, 1983

Mr. D. A. Macgregor,
Executive Director,
Alberta Hospital Association,
10025 108 Street,
Edmonton, T5J 1K9.

Dear Mr. Macgregor,

Re: Employee Relations Research

Further to our telephone conversation of the 27 April, 1983, I am forwarding a research proposal entitled: "Strikes by Nurses: A Socio-Analytic Study of a Collective Bargaining Relationship, 1977-1982."

As you know, I am a graduate student at the University of Alberta, and this study, I hope, is to be the subject of my Ph.D. dissertation. My formal defense of this proposal is scheduled for 19 May, 1983.

The focus of this study is on the three strikes by registered nurses that occurred in Alberta between the years 1977 and 1982, but the research also entails an inquiry into the history of the AHA/UNA collective bargaining relationship. Although much of the pertinent information is available in public documents, I am interested in obtaining access to past collective agreements with nurses dating back to 1965. Also, I would be interested in documents containing information with respect to the goals, objectives, and structure of collective bargaining of the Alberta Hospital Association. One problem with this type of research is that it is not always possible to specify in advance all of the relevant written materials, however, a general list of sources of data is outlined in Section VI C. of the proposal. I would also like to interview some of the people who played major roles either as negotiators, spokesmen, or committee members during the disputes.

This study will span some of the most important years in the history of hospital labour relations in Alberta, and therefore, it has potential for making a useful contribution to the literature on collective bargaining in the Canadian health field. I hope the research will be of interest to the Alberta Hospital Association.

I have no doubt that you will have some questions with respect to the disclosure of sensitive information, confidentiality, and the anonymity of people to be interviewed. I would welcome an opportunity to discuss these questions with you, and any other questions that you may have. I look forward to hearing from you.

Yours sincerely,

Judith M. Hibberd

Judith M. Hibberd

cc. Dr. C. S. Bumbarger

ALBERTA HOSPITAL ASSOCIATION

10025 - 108 STREET EDMONTON, ALBERTA T5J 1K9

Telephone 423-1776



PLEASE DIRECT
ALL CORRESPONDENCE
TO THE ASSOCIATION
AND QUOTE OUR FILE
NUMBER

May 30, 1983

Ms. Judith M. Hibberd
11325 - 67 Street
EDMONTON, Alberta
T5B 1L2

Dear Ms. *Judy* Hibberd:

RE: EMPLOYEE RELATIONS RESEARCH

This is further to your letter of May 3, 1983 and our recent telephone conversation with respect to the potential involvement of the Alberta Hospital Association in your research proposal entitled "Strikes By Nurses: A Socio-Analytic Study of a Collective Bargaining Relationship, 1977-1982."

As I indicated to you by telephone, your proposal was tabled with the Executive Committee of the Alberta Hospital Association on May 26th and I am pleased to say received the general endorsement by that Committee.

I pointed out in reviewing the matter briefly with the Executive Committee, that you and I had discussed the need to expand your proposal to include comment from other involved parties in the strike situations that you will be studying. I made particular mention of the College of Physicians and Surgeons, the Alberta Medical Association, the Department of Labour (both political and bureaucratic), the Department of Hospitals & Medical Care, (both political and bureaucratic), as well as comment from the media which not always only reports on news but is often instrumental in creating aspects of the news.

I also pointed out that with respect to the provision of A.H.A. documents and accessibility to persons involved in the process, that we maintain the ultimate caveat on sensitive or confidential documents.

The Executive Committee felt the study would make a very useful contribution to the literature on this subject and would be prepared to assist you subject to the balanced view being taken as indicated above. Perhaps on receipt of this letter you might let me know how your proposal was received by your Faculty with whom it was defended and if it would now appear that your proposal has been approved.

continued.....

- 2 -

Ms. Judith M. Hibberd
Re: Employee Relations Research

May 30, 1983

Perhaps we could get together over lunch someday and review your time frames and the kind of involvement that may be necessary with members of my staff in terms of access to reference materials.

I look forward to chatting with you about your project further at an early date.

Yours sincerely,



D.A. Macgregor
Executive Director

DAM/pp



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June 30, 1983.

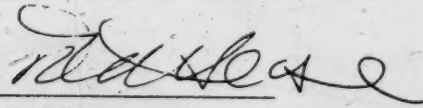
Administrators
Member Hospitals and Nursing Homes
Alberta Hospital Association

Re: Research Project - Ms. Judith M. Hibberd

The Alberta Hospital Association, on approval of its Board of Directors, is cooperating with Ms. Hibberd during the course of her preparation for a Ph.D. dissertation entitled, "Strikes By Nurses: A Socio-Analytic Study of a Collective Bargaining Relationship, 1977-1982."

Ms. Hibberd may be in touch with you or senior members of your Executive in respect of this project. We would appreciate your extending her your cooperation, particularly in interviewing certain individuals whom she feels might assist in providing a balanced perspective on this issue.

Sincerely,


R. M. Heise
Assistant Executive Director
Employee Relations

RMH/cmc

cc: Mr. D. A. Macgregor
Ms. J. M. Hibberd

APPENDIX F

Alberta Hospital Association Statement
of Philosophy on Employee Relations

APPENDIX F

Alberta Hospital AssociationStatement of Philosophy on Employee Relations

The continuing capability to provide a high quality of health care to patients is enhanced by a positive Employee Relations atmosphere. The Alberta Hospital Association is committed to assist member institutions in the promotion of positive and productive relationships with their employees which will significantly contribute to the continuing delivery of the highest quality of health care achievable in a responsible cost effective manner to the public in Alberta.

It is recognized that:

- I. the ultimate governance of the Employee Relations process is vested in local boards who may delegate this authority to the Alberta Hospital Association.
- II. for the Alberta Hospital Association to be credible and effective in collective bargaining, it is essential that those member hospitals and nursing homes who elect to delegate the authority for collective bargaining on their behalf do so on the basis that they are fully committed throughout the process of bargaining and to the acceptance of the negotiated settlement.
- III. the success of the Alberta Hospital Association in Employee Relations on behalf of its members will depend directly on the strength of the collective membership commitment to the following program objectives:
 - (1) through collective bargaining, establish fair and equitable salaries, benefits and working conditions for Alberta's health care workers that promote a continuing supply of suitably qualified manpower for employment in Alberta hospitals. Key criteria to be examined in the process of establishing A.H.A.'s total compensation guidelines are:
 - (a) local markets in the private sector that compete for similar human resource skills as are deployed in member hospitals and nursing homes;
 - (b) compensation profiles in other provinces to which Alberta health care workers relate; and
 - (c) consideration of significant relationships between positions across the various bargaining units.

These and related criteria will be examined and consequent guidelines adopted by the Employee Relations Committee of the Alberta Hospital Association and confirmed by its Board of Directors.

- (2) foster, develop and encourage joint consultation programs between local administrations and their unions as well as at the provincial level.
- (3) through consultation and education by A.H.A., promote sound managerial/employee relations practices in member facilities. Provide specific educational activities to assist members in the sound administration of their collective agreements.
- (4) advise member facilities on the planning and implementation of organizational arrangements and alternatives that will assist health care workers to realize their career aspirations.
- (5) assist member institutions in the development and implementation of performance and productivity appraisal and assessment programs to assure the public in Alberta that their health care workers and institutions are providing a fair return on the ongoing investment in the operation of a quality health care system.
- (6) continuously review, assess and develop alternative approaches in the collective bargaining process and examine new dispute resolution mechanisms with unions.
- (7) maintain good Employee Relations communications to A.H.A. members and foster an environment that will encourage full reciprocal communications from A.H.A. members.

June, 1981

